Dental Health Services Inc.

Family Dental HMO

Covered California for Small Business

Summary of Benefits and Evidence of Coverage

A Qualified Dental Plan that satisfies the pediatric dental Essential Health Benefit

Effective 01/01/2023 - 12/31/2023

0322CG249 © 2022 Dental Health Services

Table of Contents

Dental Health Services

Schedule of Covered Services and Copayments

Family Dental HMO CCSB Plan

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
	Actuarial Value	84.33%	Not Calculated
	Individual Deductible	None	None
	Family Deductible (Two or more children)	None	None
	Out of Pocket Maximum - Individual	350	None
	Out of Pocket Maximum - Family (Two or more children)	700	None
	Office Copay	0	0
	Waiting Period	None	None
	Annual Benefit Limit	None	None

All procedures listed other than those indicated as "Not Covered" are pediatric essential health benefit services and apply to the out of pocket maximum. The family out of pocket maximum applies to two or more pediatric children per plan.

Pediatric coverage is through the end of the 18th year, (up to age 19).

Administration of this plan design must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Period Screening, Diagnosis and Treatment (EPSDT) benefit.

Services must be performed by your selected Dental Health Services participating dentist. Please contact your Member Services Specialist at 855-495-0905 if you need assistance in choosing a dentist.

All referrals for specialist services must be requested by your participating dentist and pre-authorized by Dental Health Services.

Diagnostic Procedures

Please see the attached Exclusions and Limitations for more information.

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D0120	periodic oral evaluation - established patient	No Charge	No Charge
D0140	limited oral evaluation - problem focused	No Charge	No Charge
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge	Not Covered
D0150	comprehensive oral evaluation - new or established patient	No Charge	No Charge
D0160	detailed and extensive oral evaluation - problem focused, by report	No Charge	No Charge
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Charge	No Charge
D0171	re-evaluation – post-operative office visit	No Charge	No Charge
D0180	comprehensive periodontal evaluation - new or established patient	No Charge	No Charge
D0190	screening of a patient	Not Covered	No Charge
D0191	assessment of a patient	Not Covered	No Charge
D0210	intraoral - complete series of radiographic images	No Charge	No Charge
D0220	intraoral - periapical first radiographic image	No Charge	No Charge
D0230	intraoral - periapical each additional radiographic image	No Charge	No Charge
D0240	intraoral - occlusal radiographic image	No Charge	No Charge
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No Charge	No Charge
D0251	extra-oral posterior dental radiographic image	No Charge	Not Covered
D0270	bitewing - single radiographic image	No Charge	No Charge
D0272	bitewings - two radiographic images	No Charge	No Charge
D0273	bitewings - three radiographic images	No Charge	No Charge
D0274	bitewings - four radiographic images	No Charge	No Charge
D0277	vertical bitewings - 7 to 8 radiographic images	No Charge	No Charge
D0310	sialography	No Charge	No Charge
D0320	temporomandibular joint arthrogram, including injection	No Charge	No Charge
D0322	tomographic survey	No Charge	No Charge
D0330	panoramic radiographic image	No Charge	No Charge
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	No Charge	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No Charge	No Charge
D0351	3D photographic image	No Charge	No Charge
D0419	Assessment of salivary flow by measurement	Not Covered	No Charge
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	No Charge
D0460	pulp vitality tests	No Charge	No Charge
D0470	diagnostic casts	No Charge	No Charge
D0502	other oral pathology procedures, by report	No Charge	No Charge

Effective Date: 1/01/2023

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge	No Charge
D0701	panoramic radiographic image – image capture only	No Charge	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only	No Charge	No Charge
D0704	3-D photographic image – image capture only	No Charge	No Charge
D0705	extra-oral posterior dental radiographic image – image capture only	No Charge	Not Covered
D0706	intraoral – occlusal radiographic image – image capture only	No Charge	No Charge
D0707	intraoral – periapical radiographic image – image capture only	No Charge	No Charge
D0708	intraoral –bitewing radiographic image – image capture only	No Charge	No Charge
D0709	intraoral - complete series of radiographic images – image capture only	No Charge	No Charge
D0999	unspecified diagnostic procedure, by report	No Charge	No Charge

Preventive Procedures

Prophylaxis cleanings and fluoride for pediatric children are covered one (1) in a six (6) month period. Prophylaxis cleanings for adults are covered two (2) in a twelve (12) month period and fluoride is covered one (1) in a twelve (12) month period.

D1110	prophylaxis - adult	No Charge	No Charge
D1120	prophylaxis - child	No Charge	Not Covered
D1206	topical application of fluoride varnish	No Charge	No Charge
D1208	topical application of fluoride – excluding varnish	No Charge	No Charge
D1310	nutritional counseling for control of dental disease	No Charge	No Charge
D1320	tobacco counseling for the control and prevention of oral disease	No Charge	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	No Charge
D1330	oral hygiene instructions	No Charge	No Charge
D1351	sealant - per tooth	No Charge	No Charge
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No Charge	Not Covered
D1353	sealant repair – per tooth	No Charge	No Charge
D1354	Interim caries arresting medicament application per tooth	No Charge	No Charge
D1355	caries preventive medicament application – per tooth	No Charge	No Charge
D1510	space maintainer - fixed - unilateral - per quadrant	No Charge	No Charge
D1516	space maintainer - fixed - bilateral, maxillary	No Charge	No Charge
D1517	space maintainer - fixed, bilateral, mandibular	No Charge	No Charge
D1520	space maintainer - removable - unilateral - per quadrant	No Charge	No Charge
D1526	space maintainer - removable - bilateral, maxillary	No Charge	No Charge
D1527	space maintainer - removable - bilateral, mandibular	No Charge	No Charge
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Charge	No Charge
D1552	Re-cement or re-bond lateral space maintainer - mandibular	No Charge	No Charge
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Charge	No Charge
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Charge	No Charge
D1557	Removal of fixed bilateral space maintainer - maxillary	No Charge	No Charge
D1558	Removal of fixed bilateral space maintainer - mandibular	No Charge	No Charge
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No Charge	No Charge

Restorative Procedures

Amalgam and resin composite restorations are limited to one (1) in a twelve (12) month period for primary teeth and one (1) in a thirty-six (36) month period for permanent teeth. Please see the attached Exclusions and Limitations for more information about crowns.

D2140	amalgam - one surface, primary or permanent	25	25
D2150	amalgam - two surfaces, primary or permanent	30	30
D2160	amalgam - three surfaces, primary or permanent	40	40
D2161	amalgam - four or more surfaces, primary or permanent	45	45
D2330	resin-based composite - one surface, anterior	30	30
D2331	resin-based composite - two surfaces, anterior	45	45
D2332	resin-based composite - three surfaces, anterior	55	55

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment	
		Pediatric Dental EHB Up to 19	Adult Dental Age 19 and Older
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	60	60
D2390	resin-based composite crown, anterior	50	50
D2391	resin-based composite - one surface, posterior	30	30
D2392	resin-based composite - two surfaces, posterior	40	40
D2393	resin-based composite - three surfaces, posterior	50	50
D2394	resin-based composite - four or more surfaces, posterior	70	70
D2542	onlay - metallic - two surfaces	Not Covered	185
D2543	onlay - metallic - three surfaces	Not Covered	200
D2544	onlay - metallic - four or more surfaces	Not Covered	215
D2642	onlay - porcelain/ceramic - two surfaces	Not Covered	250
D2643	onlay - porcelain/ceramic - three surfaces	Not Covered	275
D2644	onlay - porcelain/ceramic - four or more surfaces	Not Covered	300
D2662	onlay - resin-based composite - two surfaces	Not Covered	160
D2663	onlay - resin-based composite - three surfaces	Not Covered	180
D2664	onlay - resin-based composite - four or more surfaces	Not Covered	200
D2710	crown - resin-based composite (indirect)	140	140
D2712	crown - ¾ resin-based composite (indirect)	190	200
D2720	crown - resin with high noble metal	Not Covered	300
D2721	crown - resin with predominantly base metal	300	300
D2722	crown - resin with noble metal	Not Covered	300
D2740	crown - porcelain/ceramic substrate	300	300
D2750	crown - porcelain fused to high noble metal	Not Covered	300
D2751	crown - porcelain fused to predominantly base metal	300	300
D2752	crown - porcelain fused to noble metal	Not Covered	300
D2753	crown - porcelain fused to titanium and titanium alloys	Not Covered	300
D2780	crown - 3/4 cast high noble metal	Not Covered	300
D2781	crown - 3/4 cast predominantly base metal	300	300
D2782	crown - 3/4 cast noble metal	Not Covered	300
D2783	crown - 3/4 porcelain/ceramic	310	310
D2790	crown - full cast high noble metal	Not Covered	300
D2791	crown - full cast predominantly base metal	300	300
D2792	crown - full cast noble metal	Not Covered	300
D2794	crown - titanium and titanium alloys	Not Covered	300
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	25	25
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	25	25
D2920	re-cement or re-bond crown	25	15
D2921	reattachment of tooth fragment, incisal edge or cusp	45	45
D2928	prefabricated porcelain/ceramic crown – permanent tooth	120	Not Covered
D2929	prefabricated porcelain/ceramic crown – primary tooth	95	Not Covered
D2930	prefabricated stainless steel crown - primary tooth	65	Not Covered
D2931	prefabricated stainless steel crown - permanent tooth	75	75
D2932	prefabricated resin crown	75	Not Covered
D2933	prefabricated stainless steel crown with resin window	80	Not Covered
D2940	protective restoration	25	20
D2941	interim therapeutic restoration – primary dentition	30	Not Covered
D2949	restorative foundation for an indirect restoration	45	Not Covered
D2950	core buildup, including any pins when required	20	20
D2951	pin retention - per tooth, in addition to restoration	25	20
D2952	post and core in addition to crown, indirectly fabricated	100	60
D2953	each additional indirectly fabricated post - same tooth	30	30
D2954	prefabricated post and core in addition to crown	90	60
D2955	post removal	60	Not Covered
D2957	each additional prefabricated post - same tooth	35	35
D2971	additional procedures to customize a crown to fit under an existing partial denture framework	35	Not Covered
D2980	crown repair necessitated by restorative material failure	50	50

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment	
		Pediatric Dental EHB Up to 19	Adult Dental Age 19 and Older
D2999	unspecified restorative procedure, by report	40	40
Endodontic Procedures			
D3110	pulp cap - direct (excluding final restoration)	20	20
D3120	pulp cap - indirect (excluding final restoration)	25	25
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	40	35
D3221	pulpal debridement, primary and permanent teeth	40	50
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	60	60
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	55	Not Covered
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	55	Not Covered
D3310	endodontic therapy, anterior tooth (excluding final restoration)	195	200
D3320	endodontic therapy, bicuspid tooth (excluding final restoration	235	235
D3330	Endodontic therapy, molar tooth (excluding final restoration)	300	300
D3331	treatment of root canal obstruction; non-surgical access	50	50
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	85
D3333	internal root repair of perforation defects	80	80
D3346	retreatment of previous root canal therapy - anterior	240	245
D3347	retreatment of previous root canal therapy - bicuspid	295	295
D3348	retreatment of previous root canal therapy - molar	365	365
D3351	apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	85	85
D3352	apexification/recalcification – interim medication replacement	45	50
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	Not Covered
D3410	apicoectomy - anterior	240	240
D3421	apicoectomy - bicuspid (first root)	250	250
D3425	apicoectomy - molar (first root)	275	275
D3426	apicoectomy (each additional root)	110	110
D3430	retrograde filling - per root	90	90
D3450	root amputation - per root	Not Covered	110
D3471	surgical repair of root resorption - anterior	160	160
D3472	surgical repair of root resorption – premolar	160	160
D3473	surgical repair of root resorption – molar	160	160
D3910	surgical procedure for isolation of tooth with rubber dam	30	50
D3920	hemisection (including any root removal), not including root canal therapy	Not Covered	120
D3950	canal preparation and fitting of preformed dowel or post	Not Covered	60
D3999	unspecified endodontic procedure, by report	100	100
Periodontal Procedures			
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	150	150
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50	50
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not Covered	135
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not Covered	70
D4249	clinical crown lengthening – hard tissue	165	200
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	265	265
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	140	140
D4263	bone replacement graft – retained natural tooth – first site in quadrant	Not Covered	105
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	Not Covered	75

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	80	80
D4266	guided tissue regeneration - resorbable barrier, per site	Not Covered	145
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not Covered	175
D4270	pedicle soft tissue graft procedure	Not Covered	155
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered	220
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not Covered	190
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	185
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	175
D4341	periodontal scaling and root planing - four or more teeth per quadrant	55	55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	30	25
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	40	40
D4355	full mouth debridement to enable a comprehensive evaluation	40	40
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	10	10
D4910	Periodontal maintenance	30	30
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	15	Not Covered
D4999	unspecified periodontal procedure, by report	350	350

Prosthodontic (Removal) Procedures

Adjustments and repairs for complete and partial dentures are covered two(2)in a twelve (12) month period. Please see attached Exclusions and Limitation for more information.

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D5110	complete denture - maxillary	300	400
D5120	complete denture - mandibular	300	400
D5130	immediate denture - maxillary	300	400
D5140	immediate denture - mandibular	300	400
D5211	maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	300	325
D5212	mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	300	325
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials rests and teeth)	335	375
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials rests and teeth)	335	375
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials rests and teeth)	275	300
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials rests and teeth)	275	300
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials rests and teeth)	330	370
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials rests and teeth)	330	370
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	375
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	375
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	375
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	375
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth) maxillary	Not Covered	250
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth) mandibular	Not Covered	250

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment	
		Pediatric Dental EHB Up to 19	Adult Dental Age 19 and Older
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) per quadrant	Not Covered	250
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) per quadrant	Not Covered	250
D5410	adjust complete denture - maxillary	20	20
D5411	adjust complete denture - mandibular	20	20
D5421	adjust partial denture - maxillary	20	20
D5422	adjust partial denture - mandibular	20	20
D5511	repair broken complete denture base, mandibular	40	30
D5512	repair broken complete denture base, maxillary	40	30
D5520	replace missing or broken teeth - complete denture (each tooth)	40	30
D5611	repair resin denture base, mandibular	40	30
D5612	repair resin denture base, maxillary	40	30
D5621	repair cast framework, mandibular	40	35
D5622	repair cast framework, maxillary	40	35
D5630	repair or replace broken retentive/clasping materials - per tooth	50	30
D5640	replace broken teeth - per tooth	35	30
D5650	add tooth to existing partial denture	35	35
D5660	add clasp to existing partial denture - per tooth	60	45
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	195
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	195
D5710	rebase complete maxillary denture	Not Covered	155
D5711	rebase complete mandibular denture	Not Covered	155
D5720	rebase maxillary partial denture	Not Covered	150
D5721	rebase mandibular partial denture	Not Covered	150
D5730	reline complete maxillary denture (direct)	60	80
D5731	reline complete mandibular denture (direct)	60	80
D5740	reline maxillary partial denture (direct)	60	75
D5741	reline mandibular partial denture (direct)	60	75
D5750	reline complete maxillary denture (indirect)	90	120
D5751	reline complete mandibular denture (indirect)	90	120
D5760	reline maxillary partial denture (indirect)	80	110
D5761	reline mandibular partial denture (indirect)	80	110
D5850	tissue conditioning, maxillary	30	35
D5851	tissue conditioning, mandibular	30	35
D5862	precision attachment, by report	90	100
D5863	overdenture – complete maxillary	300	300
D5864	overdenture – partial maxillary	300	300
D5865	overdenture – complete mandibular	300	300
D5866	overdenture – partial mandibular	300	300
D5876	add metal substructure to acrylic full denture (per arch)	Not Covered	30
D5899	unspecified removable prosthodontic procedure, by report	350	400

Maxillofacial Prosthetic Procedures

Please see the attached Exclusions and Limitations for more information.

D5911	facial moulage (sectional)	285	Not Covered
D5912	facial moulage (complete)	350	Not Covered
D5913	nasal prosthesis	350	Not Covered
D5914	auricular prosthesis	350	Not Covered
D5915	orbital prosthesis	350	Not Covered
D5916	ocular prosthesis	350	Not Covered
D5919	facial prosthesis	350	Not Covered
D5922	nasal septal prosthesis	350	Not Covered
D5923	ocular prosthesis, interim	350	Not Covered
D5924	cranial prosthesis	350	Not Covered
D5925	facial augmentation implant prosthesis	200	Not Covered
D5926	nasal prosthesis, replacement	200	Not Covered
D5927	auricular prosthesis, replacement	200	Not Covered
D5928	orbital prosthesis, replacement	200	Not Covered
D5929	facial prosthesis, replacement	200	Not Covered
D5931	obturator prosthesis, surgical	350	Not Covered

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D5932	obturator prosthesis, definitive	350	Not Covered
D5933	obturator prosthesis, modification	150	Not Covered
D5934	mandibular resection prosthesis with guide flange	350	Not Covered
D5935	mandibular resection prosthesis without guide flange	350	Not Covered
D5936	obturator prosthesis, interim	350	Not Covered
D5937	trismus appliance (not for TMD treatment)	85	Not Covered
D5951	feeding aid	135	Not Covered
D5952	speech aid prosthesis, pediatric	350	Not Covered
D5953	speech aid prosthesis, adult	350	Not Covered
D5954	palatal augmentation prosthesis	135	Not Covered
D5955	palatal lift prosthesis, definitive	350	Not Covered
D5958	palatal lift prosthesis, interim	350	Not Covered
D5959	palatal lift prosthesis, modification	145	Not Covered
D5960	speech aid prosthesis, modification	145	Not Covered
D5982	surgical stent	70	Not Covered
D5983	radiation carrier	55	Not Covered
D5984	radiation shield	85	Not Covered
D5985	radiation cone locator	135	Not Covered
D5986	fluoride gel carrier	35	Not Covered
D5987	commissure splint	85	Not Covered
D5988	surgical splint	95	Not Covered
D5991	vesiculobullous disease medicament carrier	70	Not Covered
D5999	unspecified maxillofacial prosthesis, by report	350	Not Covered

Implant Service Procedures

Please see the attached Exclusions and Limitations for more information.

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D6010	surgical placement of implant body: endosteal implant	350	Not Covered
D6011	surgical access to an implant body (second stage implant surgery	350	Not Covered
D6013	surgical placement of mini implant	350	Not Covered
D6040	surgical placement: eposteal implant	350	Not Covered
D6050	surgical placement: transosteal implant	350	Not Covered
D6055	connecting bar – implant supported or abutment supported	350	Not Covered
D6056	prefabricated abutment – includes modification and placement	135	Not Covered
D6057	custom fabricated abutment – includes placement	180	Not Covered
D6058	abutment supported porcelain/ceramic crown	320	Not Covered
D6059	abutment supported porcelain fused to metal crown (high noble metal)	315	Not Covered
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	295	Not Covered
D6061	abutment supported porcelain fused to metal crown (noble metal)	300	Not Covered
D6062	abutment supported cast metal crown (high noble metal)	315	Not Covered
D6063	abutment supported cast metal crown (predominantly base metal)	300	Not Covered
D6064	abutment supported cast metal crown (noble metal)	315	Not Covered
D6065	implant supported porcelain/ceramic crown	340	Not Covered
D6066	implant supported crown (porcelain fused to high noble alloys)	335	Not Covered
D6067	implant supported crown (high noble alloys)	340	Not Covered
D6068	abutment supported retainer for porcelain/ceramic FPD	320	Not Covered
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	315	Not Covered
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	290	Not Covered
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	300	Not Covered
D6072	abutment supported retainer for cast metal FPD (high noble metal)	315	Not Covered

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	290	Not Covered
D6074	abutment supported retainer for cast metal FPD (noble metal)	320	Not Covered
D6075	implant supported retainer for ceramic FPD	335	Not Covered
D6076	implant supported retainer FPD porcelain fused to high noble alloys	330	Not Covered
D6077	implant supported retainer for metal FPD high noble alloys	350	Not Covered
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	30	Not Covered
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	Not Covered
D6082	Implant supported crown - porcelain fused to predominately base alloys	335	Not Covered
D6083	Implant supported crown - porcelain fused to noble alloys	335	Not Covered
D6084	implant supported crown - porcelain fused to titanium and titanium alloys	335	Not Covered
D6085	provisional implant crown	300	Not Covered
D6086	implant supported crown - predominantly base alloys	340	Not Covered
D6087	implant supported crown - noble alloys	340	Not Covered
D6088	implant supported crown - titanium and titanium alloys	340	Not Covered
D6090	Repair implant supported prosthesis, by report	65	Not Covered
D6091	replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	40	Not Covered
D6092	re-cement or re-bond implant/abutment supported crown	25	Not Covered
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	35	Not Covered
D6094	abutment supported crown - titanium and titanium alloys	295	Not Covered
D6095	repair implant abutment, by report	65	Not Covered
D6096	remove broken implant retaining screw	60	Not Covered
D6097	abutment supported crown - porcelain fused to titanium and titanium alloys	315	Not Covered
D6098	implant supported retainer - porcelain fused to predominantly base alloys	330	Not Covered
D6099	implant supported retainer for FPD - porcelain fused to noble alloys	330	Not Covered
D6100	Surgical removal of implant body	110	Not Covered
D6110	implant/abutment supported removable denture for edentulous arch - maxillary	350	Not Covered
D6111	implant/abutment supported removable denture for edentulous arch - mandibular	350	Not Covered
D6112	implant/abutment supported removable denture for partially edentulous arch - maxillary	350	Not Covered
D6113	implant/abutment supported removable denture for partially edentulous arch - mandibular	350	Not Covered
D6114	implant/abutment supported fixed denture for edentulous arch - maxillary	350	Not Covered
D6115	implant/abutment supported fixed denture for edentulous arch - mandibular	350	Not Covered
D6116	implant/abutment supported fixed denture for partially edentulous arch - maxillary	350	Not Covered
D6117	implant/abutment supported fixed denture for partially edentulous arch - mandibular	350	Not Covered
D6120	implant supported retainer - porcelain fused to titanium and titanium alloys	330	Not Covered
D6121	implant supported retainer for metal FPD - predominantly base alloys	350	Not Covered
D6122	implant supported retainer for metal FPD - noble alloys	350	Not Covered
D6123	implant supported retainer for metal FPD - titanium and titanium alloys	350	Not Covered
D6190	radiographic/surgical implant index, by report	75	Not Covered
D6191	semi-precision abutment – placement	350	Not Covered
D6192	semi-precision attachment – placement	350	Not Covered
D6194	abutment supported retainer crown for FPD - titanium and titanium alloys	265	Not Covered
D6195	abutment supported retainer - porcelain fused to titanium and titanium alloys	315	Not Covered
D6199	unspecified implant procedures, by report	350	Not Covered

Fixed Prosthodontic Procedures

Please see the attached Exclusions and Limitations for more information.

D6205	pontic - indirect resin based composite	Not Covered	165
D6210	pontic - cast high noble metal	Not Covered	300
D6211	pontic - cast predominately base metal	300	300
D6212	pontic - cast noble metal	Not Covered	300
D6214	pontic - titanium and titanium alloys	Not Covered	300
D6240	pontic - porcelain fused to high noble metal	Not Covered	300
D6241	pontic - porcelain fused to predominately base metal	300	300
D6242	pontic - porcelain fused to noble metal	Not Covered	300
D6243	pontic - porcelain fused to titanium and titanium alloys	Not Covered	300

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D6245	pontic - porcelain/ceramic	300	300
D6250	pontic - resin with high noble metal	Not Covered	300
D6251	pontic - resin with predominantly base metal	300	300
D6252	pontic - resin with noble metal	Not Covered	300
D6545	retainer - cast metal for resin bonded fixed prosthesis	Not Covered	130
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	145
D6549	resin retainer - for resin bonded fixed prosthesis	Not Covered	130
D6608	retainer onlay - porcelain/ceramic, two surfaces	Not Covered	200
D6609	retainer onlay - porcelain/ceramic, three or more surfaces	Not Covered	200
D6610	retainer onlay - cast high noble metal, two surfaces	Not Covered	200
D6611	retainer onlay - cast high noble metal, three or more surfaces	Not Covered	200
D6612	retainer onlay - cast predominantly base metal, two surfaces	Not Covered	200
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	Not Covered	200
D6614	retainer onlay - cast noble metal, two surfaces	Not Covered	200
D6615	retainer onlay - cast noble metal, three or more surfaces	Not Covered	200
D6634	retainer onlay - titanium	Not Covered	200
D6710	retainer crown - indirect resin based composite	Not Covered	200
D6720	retainer crown - resin with high noble metal	Not Covered	300
D6721	retainer crown - resin with predominantly base metal	300	300
D6722	retainer crown - resin with noble metal	Not Covered	300
D6740	retainer crown - porcelain/ceramic	300	300
D6750	retainer crown - porcelain fused to high noble metal	Not Covered	300
D6751	retainer crown - porcelain fused to predominantly base metal	300	300
D6752	retainer crown - porcelain fused to noble metal	Not Covered	300
D6753	retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	300
D6781	retainer crown - 3/4 cast predominantly base metal	300	300
D6782	retainer crown - 3/4 cast noble metal	Not Covered	300
D6783	retainer crown - 3/4 porcelain/ceramic	300	300
D6784	retainer crown - 3/4 titanium and titanium alloys	300	300
D6791	retainer crown - full cast predominantly base metal	300	300
D6794	retainer crown - titanium and titanium alloys	Not Covered	300
D6930	re-cement or re-bond fixed partial denture	40	40
D6980	fixed partial denture repair necessitated by restorative material failure	95	95
D6999	unspecified fixed prosthodontic procedure, by report	350	400

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
Oral and Maxillofacial Surgery Procedures			
D7111	extraction, coronal remnants - deciduous tooth	40	40
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	65	65
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	120	115
D7220	removal of impacted tooth - soft issue	95	85
D7230	removal of impacted tooth - partially bony	145	145
D7240	removal of impacted tooth - completely bony	160	160
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	175	175
D7250	removal of residual tooth roots (cutting procedure)	80	75
D7260	oroantral fistula closure	280	280
D7261	primary closure of a sinus perforation	285	285
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	185	185
D7280	exposure of an unerupted tooth	220	220
D7283	placement of device to facilitate eruption of impacted tooth	85	85
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	180	180
D7286	incisional biopsy of oral tissue-soft	110	110
D7287	exfoliative cytological sample collection	Not Covered	35
D7288	brush biopsy - transepithelial sample collection	Not Covered	35
D7290	surgical repositioning of teeth	185	185
D7291	transspetal fiberotomy/supra crestal fiberotomy, by report	80	80
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	85	85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50	50
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	120	120
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	65	65
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	350	350
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	350	350

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment	
		Pediatric Dental EHB Up to 19	Adult Dental Age 19 and Older
D7410	excision of benign lesion up to 1.25 cm	75	75
D7411	excision of benign lesion greater than 1.25 cm	115	115
D7412	excision of benign lesion, complicated	175	175
D7413	excision of malignant lesion up to 1.25 cm	95	95
D7414	excision of malignant lesion greater than 1.25 cm	120	120
D7415	excision of malignant lesion, complicated	255	255
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	105	105
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	185	200
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	180	180
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	330	330
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	155	180
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	250	250
D7465	destruction of lesion(s) by physical or chemical method, by report	40	50
D7471	removal of lateral exostosis (maxilla or mandible)	140	140
D7472	removal of torus palatinus	145	140
D7473	removal of torus mandibularis	140	140
D7485	reduction of osseous tuberosity	105	105
D7490	radical resection of maxilla or mandible	350	350
D7510	incision and drainage of abscess - intraoral soft tissue	70	55
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	70	69
D7520	incision and drainage of abscess - extraoral soft tissue	70	70
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	80	80
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	45	45
D7540	removal of reaction producing foreign bodies, musculoskeletal system	75	75
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	125	125
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	235	235
D7610	maxilla - open reduction (teeth immobilized, if present)	140	140
D7620	maxilla - closed reduction (teeth immobilized, if present)	250	250
D7630	mandible - open reduction (teeth immobilized, if present)	350	580
D7640	mandible - closed reduction (teeth immobilized, if present)	350	480
D7650	malar and/or zygomatic arch - open reduction	350	270
D7660	malar and/or zygomatic arch - closed reduction	350	580
D7670	alveolus - closed reduction, may include stabilization of teeth	170	170
D7671	alveolus - open reduction, may include stabilization of teeth	230	230
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	350	500
D7710	maxilla - open reduction	110	110
D7720	maxilla - closed reduction	180	180
D7730	mandible - open reduction	350	390
D7740	mandible - closed reduction	290	290
D7750	malar and/or zygomatic arch - open reduction	220	220
D7760	malar and/or zygomatic arch - closed reduction	350	1100
D7770	alveolus - open reduction stabilization of teeth	135	135
D7771	alveolus, closed reduction stabilization of teeth	160	160
D7780	facial bones - complicated reduction with fixation and multiple approaches	350	440
D7810	open reduction of dislocation	350	730
D7820	closed reduction of dislocation	80	80
D7830	manipulation under anesthesia	85	85
D7840	condylectomy	350	930
D7850	surgical discectomy, with/without implant	350	900
D7852	disc repair	350	400
D7854	synovectomy	350	390
D7856	myotomy	350	600
D7858	joint reconstruction	350	860
D7860	arthrotomy	350	350
D7865	arthroplasty	350	510
D7870	arthrocentesis	90	90
D7871	non-arthroscopic lysis and lavage	150	150
D7872	arthroscopy - diagnosis, with or without biopsy	350	350
D7873	arthroscopy: lavage and lysis of adhesions	350	1200
D7874	arthroscopy: disc repositioning and stabilization	350	410

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment	
		Pediatric Dental EHB Up to 19	Adult Dental Age 19 and Older
D7875	arthroscopy: synovectomy	350	410
D7876	arthroscopy: discectomy	350	270
D7877	arthroscopy: debridement	350	430
D7880	occlusal orthotic device, by report	120	120
D7881	occlusal orthotic device adjustment	30	50
D7899	unspecified TMD therapy, by report	350	350
D7910	suture of recent small wounds up to 5 cm	35	50
D7911	complicated suture - up to 5 cm	55	75
D7912	complicated suture - greater than 5 cm	130	150
D7920	skin graft (identify defect covered, location and type of graft)	120	Not Covered
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	80	80
D7940	osteoplasty - for orthognathic deformities	160	Not Covered
D7941	osteotomy - mandibular rami	350	Not Covered
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	350	Not Covered
D7944	osteotomy - segmented or subapical	275	Not Covered
D7945	osteotomy - body of mandible	350	Not Covered
D7946	LeFort I (maxilla - total)	350	Not Covered
D7947	LeFort I (maxilla - segmented)	350	Not Covered
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	350	Not Covered
D7949	LeFort II or LeFort III - with bone graft	350	Not Covered
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	190	Not Covered
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	290	Not Covered
D7952	sinus augmentation via a vertical approach	175	Not Covered
D7955	repair of maxillofacial soft and/or hard tissue defect	200	Not Covered
D7961	buccal / labial frenectomy (frenulectomy)	120	120
D7962	lingual frenectomy (frenulectomy)	120	120
D7963	frenuloplasty	120	120
D7970	excision of hyperplastic tissue - per arch	175	176
D7971	excision of pericoronal gingiva	80	80
D7972	surgical reduction of fibrous tuberosity	100	Not Covered
D7979	non- surgical sialolithotomy	155	155
D7980	surgical sialolithotomy	155	155
D7981	excision of salivary gland, by report	120	120
D7982	sialodochoplasty	215	215
D7983	closure of salivary fistula	140	140
D7990	emergency tracheotomy	350	Not Covered
D7991	coronoidectomy	345	Not Covered
D7995	synthetic graft - mandible or facial bones, by report	150	Not Covered
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	60	Not Covered
D7999	unspecified oral surgery procedure, by report	350	350

Adjunctive Service Procedures

D9110	palliative (emergency) treatment of dental pain - minor procedure	30	28
D9120	fixed partial denture sectioning	95	95
D9210	local anesthesia not in conjunction with operative or surgical procedures	10	10
D9211	regional block anesthesia	20	20
D9212	trigeminal division block anesthesia	60	60
D9215	local anesthesia in conjunction with operative or surgical procedures	15	15
D9222	deep sedation/general anesthesia – first 15 minutes	45	45
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	45	45
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	15	Not Covered
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	60	45

Current Dental Terminology © 2022 American Dental Association. All rights reserved

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	60	45
D9248	non-intravenous conscious sedation	65	Not Covered
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	50	45
D9311	consultation with a medical health care professional	No Charge	No Charge
D9410	house/extended care facility call	50	Not Covered
D9420	hospital or ambulatory surgical center call	135	Not Covered
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	20	12
D9440	office visit - after regularly scheduled hours	45	40
D9450	case presentation, detailed and extensive treatment planning	Not Covered	No Charge
D9610	therapeutic parenteral drug, single administration	30	Not Covered
D9612	therapeutic parenteral drugs, two or more administrations, different medications	40	Not Covered
D9910	application of desensitizing medicament	20	22
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	35	50
D9942	repair and/or reline of occlusal guard	Not Covered	35
D9943	occlusal guard adjustment	Not Covered	35
D9944	occlusal guard - hard appliance, full arch	Not Covered	115
D9945	occlusal guard - soft appliance, full arch	Not Covered	115
D9946	occlusal guard - hard appliance, partial arch	Not Covered	115
D9950	occlusion analysis - mounted case	120	Not Covered
D9951	occlusal adjustment - limited	45	45
D9952	occlusal adjustment - complete	210	210
D9995	teledentistry - synchronous: real-time encounter	Not Covered	No Charge
D9996	teledentistry - asynchronous: information stored and forwarded to dentist for subsequent review	Not Covered	No Charge
D9997	Dental case management - patients with special health care needs	No Charge	No Charge
D9999	unspecified adjunctive procedure, by report	No Charge	No Charge

Orthodontic Procedures

***Medically Necessary Orthodontia is covered at a $350 copayment for children up to age 19 only.** Member cost share for Medically Necessary Orthodontia services applies to the course of treatment, not individual benefit years within a multi-year course of treatment. Member cost share applies to the course of treatment as long as the member remains enrolled in the plan. The following services are included:*

Code	Description	Copayment Pediatric Dental EHB Up to 19	Copayment Adult Dental Age 19 and Older
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Not Covered	
D8210	Removable appliance therapy	Not Covered	
D8220	Fixed appliance therapy	Not Covered	
D8660	Pre-orthodontic treatment examination to monitor growth and development	Not Covered	
D8670	Periodic orthodontic treatment visit	Not Covered	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not Covered	
D8681	Removable orthodontic retainer adjustment	Not Covered	
D8696	Repair of orthodontic appliance - maxillary	Not Covered	
D8697	Repair of orthodontic appliance - mandibular	Not Covered	
D8698	Re-cement or re-bond fixed retainer - maxillary	Not Covered	
D8699	Re-cement or re-bond fixed retainer - mandibular	Not Covered	
D8701	Repair of fixed retainer, includes reattachment - maxillary	Not Covered	
D8702	Repair of fixed retainer, includes reattachment - mandibular	Not Covered	
D8703	Replacement of lost or broker retainer - maxillary	Not Covered	
D8704	Replacement of lost or broken retainer - mandibular	Not Covered	
D8999	Unspecified orthodontic procedure, by report	Not Covered	

Please call your Dental Health Services Member Service Specialist at 855-495-0905 for a referral to a conveniently located participating orthodontist.

Current Dental Terminology © 2022 American Dental Association. All rights reserved

General Policies

The following services are not covered by your dental plan:

A. Services not consistent with professionally recognized standards of practice.
B. Cosmetic services such as tooth whitening and veneers, for appearance only, unless specifically listed.
C. Treatment for malignancies, as well as hereditary, congenital and/or developmental malformations.
D. Dispensing of drugs not normally supplied in a dental office.
E. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.
F. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.
G. Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.
H. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).
I. Procedures performed by a prosthodontist.
J. Changes in treatment necessitated by an accident of any kind.
K. Coordinator of benefits with another prepaid managed care dental plan.
L. Cost sharing payments made by each individual child for in-network covered services accrue to the child's out of pocket maximum. Once the child's individual out of pocket maximum has been reached, the plan pays all costs for covered services for that child.
M. In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family out of pocket maximum.
N. In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services do not accumulate to the family out of pocket maximum.

The following are subject to additional charges and/or limitations:

A. Treatment of dental emergencies is limited to treatment that will alleviate acute symptoms and does not cover definitive restorative treatment including, but not limited to root canal treatment and crowns.
B. Optional services: when the patient select a plan of treatment that is considered optional or unnecessary by the attending dentist, the additional cost is the responsibility of the patient.
C. Specialty referrals must be pre-approved by Dental Health Services for any treatment deemed necessary by the treating participating dentist.
D. Pre-authorization is required for all specialty services.
E. Orthodontia and implant services for adults are not covered.
F. Services performed by out of network dentists are not covered unless pre-approved by Dental Health Services.

Diagnostic General Policies (D0100-D0999)

A. D0120 is a benefit once every 6 months, per participating dentist or after six months have elapsed following comprehensive oral evaluation (D0150) with the same participating dentist.
B. D0140 and D0160 are a benefit once per member per participating dentist.
C. D0170 is a benefit up to six (6) in a three (3) month period, up to a maximum of 12 times in a twelve (12) month period.
   1. This procedure is not covered when provided on the same date of service as D0120, D0140, D0150, D0160, or D9430.
D. D0210 is a benefit once per participating dentist every thirty-six (36) months.
   1. D0210 is not a benefit to the same participating dentist within six (6) months of bitewings (D0272 and D0274).
E. D0220 is a benefit to a maximum of 20 periapicals in a twelve (12) month period to the same participating dentist, in any combination of D0220 and D0330.
   1. D0210 is not considered against the maximum of 20 periapicals in a twelve (12) month period.
   2. D0220 is payable once per participating dentist per date of service.
F. D0230 is a benefit to a maximum of 20 periapicals in a twelve (12) month period to the same participating dentist, in any combination of D0220 and D0330.
   1. D0210 is not considered against the maximum of 20 periapicals in a twelve (12) month period.
G. D0240 is a benefit up to a maximum of two (2) in a six (6) month period per participating dentist.
H. D0250 and D0270 are a benefit once per date of service.
I. D0272 is a benefit once every six (6) months per participating dentist. D0272 is not a benefit:
   1. within six (6) months of D0210, same participating dentist
   2. for a totally edentulous area.
J. D0274 is a benefit once every six (6) months per participating dentist. D0274 is not a benefit:
   1. within six (6) months of D0210, same participating dentist.
   2. for members under the age of ten (10).
K. D0320 is a benefit for a maximum of three (3) per date of service.
L. D0322 is a benefit twice in a twelve (12) month period, per participating dentist.

© 2022 American Dental Association. All rights reserved

M. D0330 is a benefit once in a thirty-six (36) month period, per participating dentist except when documented as essential for a follow-up/post-operative exam.
   1. D0330 is not a benefit for the same participating dentist, on the same date of service as D0210.
   2. D0330 shall be considered part of D0210 when taken on the same date of service with bitewings (D0272 and D0274) and a minimum of two (2) D0230 procedures.

N. D0340 is a benefit twice in a twelve (12) month period per participating dentist.

O. D0350 is a benefit up to a maximum of four (4) per date of service.

P. D0470 is a benefit once per participating dentist unless special circumstances are documented, such as trauma or pathology which has affected the course of orthodontic treatment.

Preventive General Policies (D1000-D1999)

A. D1110 is a benefit twice in a twelve (12) month period for members eighteen (18) years of age or older. frequency limitations shall apply toward prophylaxis procedure D1120. D1110 is not a benefit:
   1. when performed on the same date of service with D4210, D4211, D4260, D4261, D4341, or D4342 or D4346.
   2. to the same provider that performed periodontal maintenance (D4910) in the same calendar quarter.

B. D1120 is a benefit once in a six (6) month period for pediatric members. D1120 is not a benefit:
   1. when performed on the same date of service with D4210, D4211, D4260, D4261, D4341, D4342, or D4346.
   2. to the same provider that performed periodontal maintenance (D4910) in the same calendar quarter.

C. D1206 is a benefit once in a six (6) month period for pediatric members and a benefit once in a twelve (12) month period for members twenty-one (21) years of age and older. Frequency limitations shall apply towards D1208.

D. D1208 is a benefit once in a six (6) month period for pediatric members and a benefit once in a twelve (12) month period for members twenty-one (21) years of age and older. Frequency limitations shall apply towards D1206.

E. Sealants (D1351) are a benefit for:
   1. first, second, and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations.
   2. for pediatric members once per tooth every thirty-six (36) months per participating dentist regardless of surfaces sealed. The original participating dentist is responsible for any repair or replacement during the thirty-six (36) month period.

F. Preventive resin restorations (D1352) are a benefit for:
   1. first, second, and third permanent molars that occupy the second molar position; only for an active cavitated lesion in a pit or fissure that does not cross the DEJ.
   2. for pediatric members once per tooth every thirty-six (36) months per participating dentist regardless of surfaces sealed. The original participating dentist is responsible for any repair or replacement during the thirty-six (36) month period.

G. D1510 and D1520 are a benefit once per quadrant per member, only to maintain the space for a single tooth. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance, such as lost or non-repairable. D1510 is not a benefit:
   1. when the permanent tooth is near eruption or is Missing.
   2. for upper and lower anterior teeth.
   3. for orthodontic or tooth guidance appliances.
   4. for minor tooth movement, or
   5. for activating wires.

H. D1551 - D1553 is a benefit once per provider per applicable quadrant or arch. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition, such as displacement due to a sticky food item.

Restorative General Policies (D2000-D2999)

A. D2140, D2150, D2160, D2161, D2330, and D2391-D2394 are a benefit as follows:
   1. once in a twelve (12) month period for primary (baby) teeth.
   2. once in a thirty-six (36) month period for permanent (adult) teeth.

B. D2331, D2332, and D2335 are a benefit as outlined below and are payable once per tooth, per date of service, per unique tooth surface:
   1. once in a twelve (12) month period for primary (baby) teeth.
   2. once in a thirty-six (36) month period for permanent (adult) teeth.

C. D2390 is a benefit as outlined below and shall involve at least four (4) surfaces:
   1. once in a twelve (12) month period for primary (baby) teeth.
   2. once in a thirty-six (36) month period for permanent (adult) teeth.

CI. D2710 and D2712 are a benefit as outlined below:
   1. permanent anterior teeth for members thirteen (13) years of age and older and permanent posterior teeth for members ages thirteen (13) through twenty (20):
      a. once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. D2710 and D2712 are not a benefit for pediatric members under the age of Thirteen (13), for third molars unless the 3rd molar occupies 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests, or for use as a temporary crown.
   2. permanent posterior teeth (ages 21 and older):
      a. once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests.
      d. when the treatment plan includes an abutment crown and removable partial denture (D5211 - D5214).
      e. D2710 and D2712 are not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests, or for use as a temporary crown.

CII. D2721, D2740, D2751, D2781, D2783, and D2791 are a benefit as outlined below:
   1. permanent anterior teeth for members thirteen (13) years of age and older and permanent posterior teeth for members ages thirteen (13) through twenty (20):
      a. once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. D2721, D2740, D2751, D2781, D2783, and D2791 are not a benefit for pediatric members under the age of thirteen (13), for third molars unless the 3rd molar occupies 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
   2. permanent posterior teeth (ages 21 and older):
      a. once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests.
      d. when the treatment plan includes an abutment crown and removable partial Denture (D5211 - D5214).
      e. D2710 and D2712 are not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

F. D2910 is a benefit once in a twelve (12) month period, per participating dentist.

G. Crown recementation (D2920) is not a benefit within twelve (12) months of a previous recementation by the same participating dentist. The original participating dentist is responsible for all recementations within the first twelve (12) months following the initial placement of prefabrication or laboratory processed crowns.

H. D2929 and D2930 are a benefit once in a twelve month period.

I. D2931 is a benefit once in a thirty-six (36) month period. D2931 is not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

J. D2932 is a benefit once in a twelve (12) month period for primary teeth and once in a thirty-six (36) month period for permanent teeth. D2932 is not a benefit for 3rd molars unless the 3rd molars occupy the 1st or 2nd molar position.

K. D2933 includes the placement of a resin-based composite and is a benefit as outlined below:
   1. once in a twelve (12) month period on primary teeth.
   2. once in a thirty-six (36) month period for permanent teeth.
   3. not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

L. D2940 is a benefit once per tooth in a six (6) month period, per participating dentist.
   1. this procedure is for a temporary restoration and is not to be used as a base or liner under a restoration.
   2. D2940 is not a benefit when performed on the same date of service with an permanent restoration or crown, for same tooth, or on root canal treated teeth.

M. D2951 is a benefit for permanent teeth only, when billed with an amalgam or composite restoration on the same date of service, once per tooth regardless of the number of pins placed, for a posterior restoration when the destruction involves 3 or more connected surfaces and at least one cusp, or for an anterior restoration when extensive coronal destruction involves the incisal angle.

N. D2952 and D2954 are a benefit once per tooth

regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or lab processed) on root canal treated permanent teeth.

O. D2980 is a benefit for lab processed crowns on permanent teeth. Not a benefit within twelve (12) months of initial crown placement or previous repair from the same provider.

P. D2999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Endodontic General Policies (D3000-D3999)

A. D3220 is a benefit once per primary tooth However, not a benefit under the following:
   1. the primary tooth is near exfoliation
   2. for a primary tooth with necrotic pulp or Periapical lesion
   3. for a primary tooth that is non-restorable
   4. a permanent tooth

B. D3221 is a benefit for permanent teeth; for over-retained primary teeth with no successor; once per tooth. D3221 is not a benefit on the same date of service with any additional services on the same tooth.

C. D3222 is a benefit once per permanent tooth on vital teeth only. D3222 is not a benefit under the following circumstances:
   1. for primary teeth
   2. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable denture with cast clasps or rests
   3. on the same date of service as any other Endodontic procedures for the same tooth

D. D3230 and D3240 are a benefit once per primary tooth however, not a benefit under the following circumstances:
   1. for a primary tooth near exfoliation
   2. with therapeutic pulpotom (excluding final restoration (D3220)) on the same date of service, same tooth
   3. with pulpal debridement (D3221), on primary or permanent teeth on the same date of service, same tooth

E. D3310 and D3320 is a benefit once per tooth for initial root canal therapy treatment. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals.

F. D3330 is a benefit once per tooth for initial root canal therapy treatment. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals. D3330 is not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

G. D3346, D3347, and D3348 include all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals; not a benefit to the original participating dentist within twelve (12) months of initial treatment. D3348 is not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

H. D3351 and D3352 are a benefit for members under the age of 21, once per permanent tooth only and are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps and rests; on the same date of service as any other endodontic procedures for the same tooth. D3352 is a benefit only when following D3351.

I. D3410, D3421, D3425, and D3426 are a benefit for permanent teeth only and include the placement of retrograde filling material and all treatment and post treatment radiographs. The procedure is not a benefit to the original participating dentist within 90 days of root canal therapy except when a medical necessity is documented or within 24 months of a prior apicoectomy/peririadicular surgery, same root.
   1. D3410 is for permanent anterior teeth only.
   2. D3421 is for permanent premolar teeth only.
   3. D3425 is for permanent 1st and 2nd molar teeth only; 3rd molar will be covered only when occupying the 1st or 2nd molar position or as an abutment for an existing fixed partial denture or removable partial denture with cast clasps and rests.
   4. D3426 is only payable on the same date of service as procedures D3421 and D3425.

J. D3430 and D3910 are to be performed in conjunction with endodontic procedures and is not payable separately. D3910 is included in the fees for restorative and endodontic procedures (D2900-D3999).

K. D3999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Periodontal General Policies (D4000-D4999)

A. D4210, D4211, D4260, and D4261 are a benefit for members ages thirteen (13) and older, once per quadrant Every thirty-six (36) months. These procedures require prior-authorization and cannot be prior-authorized within thirty (30) days following periodontal scaling and root planing (D4341/D4342) for the same quadrant. D4260 and D4261can only be prior-authorized when

preceded by D4341/D4342 in the same quadrant within the previous twenty-four (24) months.

B. D4283 and D4285 are a benefit for members 19 years of age and older.
   1. D4283 will be covered following treatment for D4273 per tooth, implant, or edentulous tooth position once per thirty-six (36) months.
   2. D4285 will be covered following treatment for D4275 per tooth, implant, or edentulous tooth position once per thirty-six (36) months.

C. D4341 and D4342 are a benefit for members ages thirteen (13) and older, once per quadrant every twenty-four (24) months. D4210, D4211, D4260, and D4261 cannot be prior-authorized within thirty (30) days following these procedures for the same quadrant.
   1. Prophylaxis (D1110/D1120) are not payable on the same date of service.

D. D4910 is a benefit once in a calendar quarter and only when preceded by a completion of all necessary scaling and root planing (D4341/ D4342); only in the twenty-four (24) month period following the last scaling and root planing.
   1. D4910 is not a benefit in the same calendar quarter as D4341/D4342 and is not payable to the same participating dentist in the same calendar quarter as D1110/D1120.
   2. D4910 is considered a full mouth treatment

E. D4920 is a benefit for members ages 13 and older, once per member per participating dentist within thirty (30) days of the date of service of D4210, D4211, D4260, and D4261.
   1. D4920 by the same provider are considered Part of, and included in the fee for D4210, D4211, D4260, and D4261.

F. D4999 is a benefit for members ages thirteen (13) and older and shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Prosthodontics (Removable) General Policies (D5000-D5899)

A. D5110 and D5120 are a benefit once in a five (5) year period from a previous complete, immediate, or overdenture-complete denture.
   All adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure.

B. D5130 and D5140 are a benefit once per member, all adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure. D5130/D5140 are not a benefit under the following circumstances:
   1. as a temporary denture.
   2. subsequent complete dentures within a five (5) year period of an immediate denture.

C. D5211 and D5212 are a benefit once in a five (5) year period and when replacing a permanent anterior tooth or teeth and/or where the arch lacks posterior balanced occlusion. All adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure. Lack of posterior balanced occlusion is defined as follows:
   1. five (5) permanent posterior missing teeth, (excluding 3rd molars).
   2. all four 1st and 2nd permanent molars missing.
   3. 1st and 2nd permanent molars and bicuspids missing on the same side.

   These procedures are not a benefit when replacing 3rd molars and are not eligible for laboratory relines (D5760/D5761).

D. D5213 and D5214 are a benefit once in a five (5) year period and when opposing a full denture and the arch lacks posterior balanced occlusion. All adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure. Lack of posterior balanced occlusion is defined as follows:
   1. five (5) permanent posterior missing teeth, (excluding 3rd molars).
   2. all four 1st and 2nd permanent molars missing.
   3. 1st and 2nd permanent molars and bicuspids missing on the same side.

   These procedures are not a benefit when replacing 3rd Molars.

E. D5410, D5411, D5421, and D5422 are a benefit once per date of service per participating dentist twice in a twelve (12) month period, per participating dentist. Adjustments needed within six (6) months of the date of service for D5110, D5120, D5130, D5140, D5211, and D5212-D5214 are included in the fee for those procedures.
   1. D5410 is not a benefit on the same date of service Or within six (6) months as D5110 or D5130, D5730, D5740, D5750, D5850, D5511, D5512, or D5520.
   2. D5411 is not a benefit on the same date of service Or within six (6) months as D5120 or D5140, D5731, D5741, D5751, D5851, D5511, D5512, or D5520.
   3. D5421 is not a benefit on the same date of service Or within six (6) months as D5211 or D5213, D5740, D5760, D5850, D5611, D5612, D5630, D5640, D5650, or D5660.
   4. D5422 is not a benefit on the same date of service or within six (6) months as D5212 or D5214, D5741, D5761, D5851, D5611, D5612, D5621, D5622, D5630, D5640, D5650, or D5660.

F. D5511 and D5512 are a benefit once per arch, per date of service per participating dentist, twice in a twelve (12) month period per participating dentist. All adjustments made within six (6) months after the date of repair, by

the same dentist and same arch, are included in the fee for this procedure.

1. D5511 and D5512 are not a benefit on the same date of service as D5730, D5731, D5750 orD5751.

G. D5520 is a benefit up to a maximum of four, per arch, per date of service per participating dentist, twice per arch, in a twelve (12) month period per participating dentist. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

H. D5611 and D5612 are a benefit once per arch, per date of service per participating dentist, and twice per arch in a 12 month period per participating dentist for partial dentures only. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

1. D5611 and D5612 are not a benefit on the same date of service as D5740, D5741, D5760 or D5761.

I. D5621 and D5622 are a benefit once per arch, per date of service per participating dentist, and twice per arch in a 12 month period per participating dentist. All adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

J. D5630 and D5660 are a benefit up to a maximum of three (3), per date of service per participating and twice per arch in a 12 month period per participating dentist. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

K. D5640 is a benefit up to a maximum of four (4) per arch, per date of service per participating dentist dentist, for partial dentures only. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

L. D5650 is a benefit up to a maximum of three (3) per date of service per participating dentist, once per tooth. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

1. Adding 3rd molars is not a benefit.

M. D5730 and D5731 are a benefit once in a twelve (12) month period; six months after the date of service for a removable denture (D5130/D5140) that required extractions or (D5110, D5120) that did not require extractions D5730 and D5731 are not a benefit under the following circumstance:

1. within twelve (12 months of a reline (D5750/D5751).

All Adjustments made within six (6) months after the date of service by the same dentist, are included in the fee for this procedure.

N. D5740 and D5741 are a benefit once in a twelve (12) month period; six months after the date of service for a removable denture (D5211-D5214) that required extractions or twelve (12) months after the date of service for D5213/D5214 that did not require extractions. All Adjustments made within six (6) months after the date of service by the same dentist, are included in the fee for this procedure.

O. D5750 and D5751 are a benefit once in a twelve (12) month period; six months after the date of service for an immediate denture (D5130/D5140) that required extractions or twelve (12) months after the date of service for D5110/D5120 that did not require extractions. D5750 and D5751 are not a benefit under the following circumstance:

1. within twelve (12 months of a reline (D5730/D5731).

All adjustments made within six (6) months after the date of service by the same dentist, are included in the fee for this procedure.

P. D5760 and D5761 are a benefit once in a twelve (12) month period; six months after the date of service for an removable denture (D5211-D5214) that required extractions or twelve (12) months after the date of service for D5211-D5214 that did not require extractions. D5760 and D5761 are not a benefit under the following circumstances:

1. within twelve (12 months of a reline (D5740/D5741).
2. for a partial dentures with resin base (D5211/D5212).

All adjustments made within six (6) months after the date of service by the same dentist, are included in the fee for this procedure.

Q. D5850 and D5851 are a benefit twice per prosthesis in a thirty-six (36) month period however, are not a benefit on the same date of service as D5730, D5731, D5740, D5741, D5750, D5751, D5760, or D5761 or on the same date of service as a prosthesis that did not require extractions. All adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure.

R. D5899 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Maxillofacial Prosthetic General Policies (D5900-D5999)

A. D5916 is not a benefit on the same date of service as ocular prosthesis, interim (D5923).

B. D5923 is not a benefit on the same date of service with ocular prosthesis(D5916).

C. D5931 and D5932 are not a benefit on the same date of service as obturator prosthesis, interim (D5936).

1. D5931 is not a benefit on the same date of service as D5932.
2. D5932 is not a benefit on the same date of service as D5931.

D. D5933 is a benefit twice in a twelve (12) month period and not a benefit on the same date of service as D5931, D5932, or D5936.
E. D5951-D5953 are a benefit for pediatric members up to age nineteen (19).
F. D5955 is not a benefit on the same date of service as D5958.
G. D5958 is not a benefit on the same date of service as D5955.
H. D5959 is a benefit twice in a twelve (12) month period and not a benefit on the same date of service as D5955 or D5958.
I. D5960 is a benefit twice in a twelve (12) month period and not a benefit on the same date of service as D5952 or D5953.
J. D5999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Implant Services General Policies (D6000-D6199)

A. Implant services require prior-authorization and are only a benefit when exceptional medical conditions are documented; each case shall be reviewed for medical necessity.
B. Implant services are only a benefit for pediatric members up to age nineteen (19).
C. Re-cementation of implant/abutment-supported crowns (D6092/D6093) are not a benefit within twelve (12) months of a previous re-cementation by the same participating dentist.
   1. the original participating dentist is responsible For all re-cementations within the first twelve (12) months following the initial placement of The implant/abutment-supported crown/ fixed partial denture.

D. D6190 is included in the fee for surgical placement of an implant body (D6010).

Fixed Prosthodontic General Policies (D6200-D6999)

A. D6211, D6241, D6245, and D6251 is a benefit once in a five year (5) period for members thirteen (13) years of age and older and only when the criteria is met for a removable denture (D5211-D5214)
   1. D6211 is a benefit only when billed the Same date of service as D6721, D6740, D6751, D6781, D6783, and D6791.

B. D6721, D6740, D6751, D6781, D6783, and D6791 are a benefit once in a five (5) year period for members thirteen (13) years of age and older and only when the criteria has been met for a removable denture (D5211-D5214).
C. Re-cementation of a fixed partial denture (D6930) is not a benefit within twelve (12) months of a previous re-cementation by the same participating dentist.
   1. the original participating dentist is responsible for all re-cementations within the first twelve (12) months following the initial placement of the fixed partial denture.

D. D6980 is not a benefit within 12 months of the initial placement or previous repair, same participating dentist.
E. D6999 is not a benefit within twelve (12) months of initial placement, same participating dentist, and shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Maxillofacial Surgery General Policies (D7000-D7999)

A. D7111 is not a benefit for asymptomatic teeth.
B. D7140 is not a benefit to the same participating dentist who performed the initial tooth extraction.
C. D7260 is not a benefit in conjunction with extractions procedures (D7111-D7250).
D. D7270 is a benefit once per arch regardless of the number of teeth involved and for permanent teeth only. The fee for this service includes splinting and/or stabilization, post-operative care and the removal of the splint or stabilization, by the same participating dentist.
E. D7280 is not a benefit for members ages twenty-one (21) years of age and older or for 3rd molars.
F. D7283 is only a benefit for members in active orthodontic treatment. D7283 is not a benefit under the following circumstances:
   1. Members twenty-one (21) years of age and older.
   2. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

G. D7285 is a benefit for the removal of specimen only; once per arch, per date of service regardless of the areas involved. D7285 is not a benefit with:
   1. an apicoectomy/perirdicular surgery D3410-D3426 in the same area, region, or on the same date of service.
   2. an extraction D7111-D7250 in the same area, region, or on the same date of service.
   3. an excision of any soft tissues or lesions D7410-D7461 in the same area, region, or on the same date of service.

H. D7286 is a benefit for the removal of specimen only; up to a maximum of three (3) per date of service. D7285 is not a benefit with:
   1. an apicoectomy/perirdicular surgery D3410-D3426 in the same area, region, or on the same date of service.

2. an extraction D7111-D7250 in the same area, region, or on the same date of service.
3. an excision of any soft tissues or lesions D7410-D7461 in the same area, region, or on the same date of service.

I. D7290 is a benefit for members in active orthodontic treatment, once per arch, on permanent teeth only. D7290 is not a benefit under the following circumstances:
   1. members twenty-one (21) years of age and older
   2. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

J. D7291 is a benefit only for members in active orthodontic treatment, once per arch and not a benefit for members twenty-one (21) years of age and older.

K. D7310 is a benefit with two (2) or more extractions (D7140-D7250) in the same quadrant, on the same date of service.

L. D7320 is a benefit regardless of the number of tooth/teeth spaces however, not a benefit within six (6) months following D7140-D7250, in the same quadrant, by the same participating dentist.

M. D7340 and D7350 are a benefit once per arch and not a benefit on the same date of service D7111-D7250 on the same arch.
   1. D7340 is not a benefit on the same date of service as D7350 and a limited to once in a five (5) year period.
   2. D7350 is not a benefit on the same date of service as D7340.

N. D7471 is a benefit once per quadrant, for the removal of buccal or facial exostosis only.

O. D7472 is a benefit once in the member's lifetime.

P. D7473 and D7485 is a benefit once per quadrant.

Q. D7510 and D7511 is a benefit once per quadrant, same date of service. The fee for this procedure includes the incision, placement and removal of a surgical draining device.
   1. any other definitive treatment performed in the same quadrant on the same date of service, except necessary radiographs, are not a benefit.

R. D7520 and D7521 includes the incision, placement and removal of a surgical draining device.

S. D7530 and D7540 are a benefit once per date of service and not a benefit when associated with the removal of a tumor, cyst (D7440-D7461), or tooth (D7111-D7250).

T. D7550 is a benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. D7550 is not a benefit within thirty (30) days of an associated extraction.

U. D7560 is not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

V. D7610-D7771 include the placement and removal of wires, bands, splints, and arch bars. Anesthesia procedures (D9222-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints, or arch bars.

W. D7780 is a benefit for the treatment of compound fractures. The fee for this procedure includes the placement and removal of wires, bands, splints, and arch bars. Anesthesia procedures (D9222-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints, or arch bars.

X. Anesthesia procedures are a separate benefit when necessary for manipulation under anesthesia (D7830).

Y. D7872 includes the fee for any biopsies performed.

Z. D7880 is a benefit for those diagnosed with TMJ dysfunction however, not a benefit for the treatment of bruxism.

AA. D7899 is not a benefit for procedures such as acupuncture, acupressure, biofeedback, or hypnosis.

BB. D7910-D7912 are not a benefit for the closure of surgical incisions.

CC. D7920, D7950, and D7995 are not a benefit for periodontal grafting.

DD. D7951 and D7952 are a benefit only for members with prior-authorized implant services.

EE. D7963 is a benefit once per arch, per date of service and only when the permanent incisors and cuspids have erupted.

FF. D7970-D7972 include the fees for other surgical procedures that are performed in the same area, on the same date of service. These procedures are not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
   1. D7970 is a benefit once per arch per date of service.
   2. D7972 is a benefit once per quadrant per date of service.

GG. D7997 is a benefit once per arch per date of service and for the removal of orthodontic appliances and space maintainers.

HH. D7999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Orthodontic General Policies (D8000-D8999)

A. D8080 is a benefit for handicapping malocclusion, cleft palate and facial growth management cases, for pediatric members up to age 19 and permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly), once per member per phase of treatment. All appliances such as bands, arch

wires, headgear and palatal expanders) are included in the fee for this procedure. This procedure also includes the replacement, repair and removal of brackets, bands, and arch wires by the original participating dentist.

B. D8210 and D8220 are a benefit for members ages six (6) through twelve (12), once per member. This procedure includes all adjustments to the appliance. These procedures are not a benefit as outlined below:
   1. for orthodontic appliances
   2. tooth guidance appliances
   3. minor tooth movement or activating wires
   4. for space maintainers in the upper or lower anterior region.

C. D8660 is a benefit prior to comprehensive orthodontic treatment (D8080) of the adolescent dentition for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three (3) months, for pediatric members up to age 19; for a maximum of six.

D. D8670 is a benefit for pediatric members up to age 19; for permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter. The maximum quantity of monthly treatment visits for the following phases are:
   1. Malocclusion– up to a maximum of eight (8) quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity.
   2. Cleft palate-
      a. primary dentition: up to a maximum of four (4) quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      b. Mixed dentition: up to a maximum of five (5) quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      c. Permanent dentition: up to a maximum of ten (10) quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
   3. Facial growth management-
      a. primary dentition: up to a maximum of four (4) quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      b. Mixed dentition: up to a maximum of five (5) quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      c. Permanent dentition: up to a maximum of eight (8) quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

E. D8680 is a benefit for pediatric members up to age 19 and permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly), once per arch for each authorized phase of orthodontic treatment. D8680 is not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680). The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

F. D8999 is a benefit for pediatric members up to age 19 and not a benefit to the original participating dentist for the adjustment, repair, replacement or removal of brackets, bands, or arch wires. Procedure D8999 shall be used for a procedure which is not adequately described by a CDT code, or for a procedure that has a CDT code that is not a benefit but the member has an exceptional medical condition to justify the medical necessity.

Adjunctive Service General Policies (D9000-D9999)

A. D9110 is a benefit once per date of service per participating dentist regardless of the number of teeth and/or areas treated. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

B. D9120 is a benefit when at least one of the abutment teeth is to be retained.

C. D9210 is a benefit once per date of service per participating dentist, only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.

D. D9222 and/or D9223 is a not a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239 and/or D9243) or non-intravenous conscious sedation (D9248), when all associated procedures on the same date of service by the same participating dentist are denied.

E. D9230 is a benefit for uncooperative members under the age of 13, or members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the member from responding to the participating dentist's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9222/D9223), intravenous conscious sedation/analgesia (D9239/ D9243) or non-intravenous conscious sedation (D9248), when all associated procedures on the same date of service by the same participating dentist are denied.

F. D9239 and/or D9243 is not a benefit on the same date of service as deep sedation/general anesthesia (D9222/D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248), when all associated procedures on the same date of service by the same participating dentist are denied.

G. D9248 is a benefit for uncooperative members under the age of 13, or members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the member from responding to the participating dentist's attempts to perform treatment; for oral, patch, intramuscular, or subcutaneous routes of administration; once per date of service. Not a benefit on the same date of service as deep sedation/ general anesthesia (D9222/D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation (D9239/D9243), when all associated procedures on the same date of service by the same participating dentist are denied.

H. D9410 is a benefit once per member per date of service, only in conjunction with procedures that are payable.

I. D9420 is a benefit for each hour or fraction thereof as documented on the operative report. Not a benefit for an assistant surgeon; for time spent compiling the member history, writing reports, or for post-operative follow up visits.

J. D9430 is a benefit once per date of service per participating dentist. Not a benefit when procedures other than necessary radiographs and/or photographs are provided on the same date of service.

K. D9440 is a benefit once per date of service per participating dentist, only with treatment that is a benefit.

L. D9610 is a benefit for up to a maximum of four (4) injections per date of service. Not a benefit for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9222/D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239/D9243) or non-intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same participating dentist are denied.

M. D9910 is a benefit once in a 12 month period per participating dentist, for permanent teeth only. Not a benefit when used as a base liner or adhesive under a restoration; the same date of service as fluoride (D1206 and D1208).

N. D9930 is a benefit once per date of service per participating dentist, for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction, for the removal of bony fragments within 30 days of the date of service of an extraction. Not a benefit for the removal of bony fragments on the same date of service as an extraction, for routine post-operative visits.

O. D9950 is a benefit once in a twelve (12) month period, for members age 13 or older, for diagnosed TMJ dysfunction only, for permanent dentition. Not a benefit for bruxism only. The fee for this procedure includes face bow, inter-occlusal record tracings, diagnostic wax up and diagnostic casts.

P. D9951 is a benefit once in a twelve (12) month period per quadrant per participating dentist, for members age 13 or older, for natural teeth only. Not a benefit within 30 days following definitive, restorative, endodontic, removable, and fixed prosthodontic treatment in the same or opposing quadrant.

Q. D9952 is a benefit once in a twelve (12) month period following occlusion analysis-mounted case (D9950), for members age 13 or older, for TMJ dysfunction only, for permanent dentition. Not a benefit in conjunction with an occlusal orthotic device (D7880). Occlusion analysis-mounted case (D9950) must precede this procedure.

R. Procedure D9999 shall be used for a procedure which is not adequately described by a CDT code, or for a procedure that has a CDT code that is not a benefit but the member has an exceptional medical condition to justify the medical necessity.

Non-Discrimination Notice

Dental Health Services complies with applicable federal civil rights lawsand does not discriminate on the basis of race, color, national origin, age, disability, or gender.

Dental Health Services:

- Provides free services for people with disabilities to communicate effectively with us, such as qualified sign language interpreters andwritten information in large print, accessible electronic and other formats.

- Provides free language services to people whose primary language isnot English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at 855.495.0905,711 (TDD/TTY).

If you believe that Dental Health Services has failed to provide these services or discriminated in any other way on the basis of race, color national origin, age, disability, or gender, you can file a grievance withthe Dental Health Services Member Satisfaction Team, by mail: 3780 Kilroy Airport Way, Suite 750, Long Beach, California 90806 call 855.495.0905, 711 (TDD/TTY), fax 562-424-0150, or email membersatisfactionteam@dentalhealthservices.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal Available at http://https//ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phoneat: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800- 868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English:
This notice has important information. This notice has important information about your application or coverage through Dental Health Services. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-866-756-4259.

Spanish
Este aviso tiene información importante. Este aviso tiene información importante acerca de su solicitud o cobertura por medio de Dental Health Services. Es posible que haya fechas clave en este aviso. Es o ayuda con los costos. Usted tiene derecho a obtener esta información y ayuda en su idioma de forma gratuita. Llame al 1-866-756-4259

Chinese
本通知包含重要資訊。本通知包含關於您的Dental Health Services申請或保險的重要資訊。本通知中可能包含重要日期。您可能需要在特定截止日期之前採取行動，以維持您的健康保險或幫助解決費用相關問 題。您有權免費獲取本資訊與以您母語進行的幫助。致電1-866-756-4259

Vietnamese
Thông báo này có các thông tin quan trọng. Thông báo này có các thông tin quan trọng về đơn yêu cầu hay bảo hiểm của quý vị thông qua Dental Health Services. Có thể có những ngày quan trọng trong thông báo này. Quý vị có thể cần hành động chậm nhất vào một số thời hạn cuối cùng để duy trì bảo hiểm y tế của quý vị hoặc để được trợ giúp với các chi phí. Quý vị có quyền nhận thông tin này và được trợ giúp miễn phí bằng ngôn ngữ của quý vị. Gọi 1-866-756-4259

Tagalog
Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon. Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Dental Health Services. Malamang na mayroong mga mahalagang petsa sa paunawang ito. Baka kailanganin ninyong magsagawa ng hakbang bago ang pagsapit ng mga partikular na deadline para mapanatili ang coverage ng inyong kalusugan o makatulong sa mga gastusin. Mayroon kayong karapatang makatanggap ng mga impormasyong ito at matulungan sa lengguahe nang walang bayad. Tumawag sa 1-866-756-4259

Korean
본 안내문에는 중요 정보가 있습니다. 본 안내문에는 Dental Health Services를 통한 귀하의 보험 또는 신청서에 관한 중요 정보가 포함되어 있습니다. 본 안내문에 중요 날짜가 적혀 있을 수 있습니다. 본인의 건강 보험 또는 비용 보조를 유지하려면 특정 마감일까지 조치를 취하셔야 할 수도 있습니다. 관련 정보를 본인의 사용 언어로 무료로 받아볼 권리가 있습니다. 1-866-756-4259번으로 전화하십시오

Armenian
Այս ծանուցումը կարևոր տեղեկատվություն է պարունակում: Այս ծանուցումը կարևոր տեղեկատվություն է պարունակում ձեր դիմումի կամ Dental Health Services-ի միջոցով տրամադրվող ապահովագրության մասին: Այս ծանուցումը կարող է պարունակել կարևոր ամսաթվեր: Ձեզնից կարող է պահանջվել որոշակի վերջնաժամկետներում կոնկրետ գործողություն կատարել՝ ձեր առողջապահական ապահովագրությունը պահպանելու կամ ծախսերին աջակցելու համար: Դուք իրավունք ունեք անվճար ստանալ այս տեղեկատվությունը և օգնությունը ձեր լեզվով: Զանգահարեք 1-866-756-4259

Farsi
این اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و طرح پوشش بیمه Dental Health Services است. ممکن است تاریخ های مهمی در این اعلامیه عنوان شده باشد. ممکن است لازم باشد تا تاریخ خاصی اقداماتی را انجام دهید تا پوشش بیمه تان حفظ شود یا کمک مالی دریافت کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی ها را به زبان خودتان و به صورت رایگان دریافت کنید. با شماره 4259-756-866-1 تماس بگیرید

Russian
Данное извещение содержит важную информацию. Данное извещение содержит важную информацию о Вашем заявлении или страховом покрытии услуг стоматологии. Извещение может содержать ключевые даты. Возможно Вам необходимо будет предпринять соответствующие действия в определенных временных рамках. Вы имеете право на получение данной информации и помощи на своем родном языке. Позвоните по телефону 1-866-756-4259

Japanese
本通知には、重要な情報が含まれています。 本通知には、Dental Health Servicesによる、お客様の申請または保障に関する重要な情報が含まれています。 本通知には、重要な日付が含まれる場合があります。 お客様の医療保障を維持するため、または、費用を節約するため、特定の期限までに行わなければならない項目がある場合があります。 お客様には、無料で、この情報を取得し、お客様の言語でサポートを受ける権利があります。 1-866-756-4259にお電話をおかけください

Panjabi
ਇਸ ਸੰਦੇਸ਼ ਿਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਿਦੱਤੀ ਗਈ ਹੈ। ਇਸ ਨੋਿਟਸ ਿਵਚ ਤੁਹਾਡੀ ਅਰਜ਼ੀ ਜਾਂ Dental Health Services ਬਾਰੇ ਜਾਣਕਾਰੀ ਿਦੱਤੀ ਗਈ ਹੈ। ਇਸ ਸੂਚਨਾ ਿਵਚ ਿਵਸ਼ੇਸ਼ ਿਮਤੀਆਂ ਿਦੱਤੀਆਂ ਹੋ ਸਕਦੀਆਂ ਹਨ। ਤੁਹਾਨੂੰ ਆਪਣੀ ਿਸਹਤ ਕਵਰੇਜ ਅਤੇ ਕੀਮਤ ਿਵਚ ਮਦਦ ਲਈ ਕੁੱਝ ਸਮਾਂ ਸੀਮਾਵਾਂ ਅੰਦਰ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪੈ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਸ ਸੂਚਨਾ ਨੂੰ ਪਰ੍ਾਪਤ ਕਰਨ ਅਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵਚ ਮੁਫਤ ਮਦਦ ਪਰ੍ਾਪਤ ਕਰਨ ਦਾ ਹੱਕ ਹਾਿਸਲ ਹੈ। 1-866-756-4259 ‘ਤੇ ਕਾਲ ਕਰੋ।

Cambodian
ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗ។ ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំរបស់លោកអ្នក ឬការធានារ៉ាប់រងតាមរយៈ Dental Health Services ។ អាចមានកាលបរិច្ឆេទសំខាន់ៗនៅក្នុងការ ជូនដំណឹងនេះ។ លោកអ្នកអាចចាំបាច់ត្រូវចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ដើម្បីទុកការធានារ៉ាប់ រងសុខភាពរបស់លោកអ្នក ឬជួយខាងថ្លៃចំណាយ។ លោកអ្នក មានសិទ្ធិដើម្បីទទួល បានព័ត៌មាននេះ ហើយ ជួយជាភាសាលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅ 1-866-756-4259

Hmong
Tsab ntawv ceeb toom no muaj lus qhia tseem ceeb. Tsab ntawv ceeb toom no muaj lus qhia tseem ceeb txog koj cov ntaub ntawv thov kev pab los yog kev pab them nqi kho mob uas koj tau txais los ntawm Dental Health Services. Tej zaum nws kuj yuav muaj qee hnub uas tseem ceeb nyob rau tsab ntawv ceeb toom nod. Koj yuav tsum tau ua raws nraim li cov sij hawm uas teem tseg txhawm rau ceev kom tau koj cov kev pab them nqi kho mob los yog cov kev pab uas muaj pab rau koj. Koj muaj cai tau txais cov lus qhia no thiab kev pab txhais hais ua koj hom lus pab dawb rau koj. Hu rau tus xov tooj 1-866-756-4259

Hindi
इस नोटिस में महत्वपूर्ण जानकारी दी गई है। इस नोटिस में Dental Health Services के जरिए आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में महत्वपूर्ण तिथियाँ हो सकती हैं। आपको कुछ समयसीमाओं के भीतर कार्रवाई करनी पड़ेंगी ताकि आपकी हेल्थ कवरेज या सशुल्क सहायता जारी रह सके। आपको यह अधिकार है कि यह जानकारी और सहायता अपनी भाषा में बिना किसी शुल्क के प्राप्त करें। इस नंबर पर कॉल करें: 1-866-756-4259

Thai
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลสำคัญเกี่ยวกับการใช้งานหรือความคุ้มครองของ Dental Health Services อาจมีวันที่สำคัญในประกาศนี้ คุณอาจต้องดำเนินการภายในกำหนดเวลาเพื่อรักษาสภาพความคุ้มครองด้านสุขภาพของคุณหรือรับความช่วยเหลือด้านค่าใช้จ่าย คุณมีสิทธิ์ได้รับข้อมูลนี้และความช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่าย โทร 1-866-756-4259

Language and CommunicationAssistance

Good communication with Dental Health Services and with your dentist is important. Dental Health Services' Language Assistance Program (LAP) provides free translation and interpreter services even if you have a family member or friend who can assist you. Should you decide to decline translation or interpreter services, DentalHealth Services will respectively and proactively note yourrequest to decline LAP services to your account for reference.

Dental Health Services' network of Quality Assured Dentists also comply with the LAP program. Please review the Directory of Participating Dentists to connectwith a dentist of your preferred language.

If English is not your first language, Dental HealthServices provides free interpretation services and translation of certain written materials including enrollment materials and plan information.

To ask for language services, or if you have a preferred language, please notify us of your personal language needsby calling 855-495-0905.

If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance bycalling 711 (TDD/TTY).

Your Personal Dental Plan

Welcome to Dental Health Services!

We want to keep you smiling by helping you protectyour teeth, saving you time and money. We are proud to offer you and your family excellent dental coverage that offers the following advantages:

- Encourages treatment by eliminating the burdens of deductibles and plan maximums.
- Makes it easy to receive your dental care without claim forms for most procedures.
- Recognizes that receiving regular diagnosticand preventive care with low, or no Copayments is the key to better health and long-termsavings.
- Facilitates care by making all covered servicesavailable as soon as membership becomes effective.
- Simplifies access by eliminating pre- authorization for treatment from your Designated Participating Primary Dentistyou've selected from our network.
- Assures availability of care with high qualityeasy-to-find dental offices throughout our Service Area.
- Sets no age limits or enrollment restrictions because dental maintenance is always important.
- Allows you to take an active role in your dental health and treatment by fully disclosingcoverage and exact Copayments prior to receiving treatment.

In addition to your ongoing dental hygiene and care,the following are available for plan Members:

- ToothTips[sm] oral health information sheets
- Member Services Specialists to assist you bytelephone, fax, or email
- Web access to valuable plan and oral healthinformation at www.dentalhealthservices.com/CA

About Dental Health Services

Dental Health Services is an employee-owned company founded by a pioneering dentist whose vision was to provide patient-focused, innovative, quality dental coverage that emphasizes overall oralhealth and wellness. These core values continue to guide and set Dental Health Services apart in the dental health industry.

Dental Health Services has been offering dental benefits along the West Coast to groups and individuals for over forty years. We are dedicated to assuring your satisfaction and to keeping your plan assimple and clear as possible.

As employee-owners, we have a vested interest in thewell-being of our plan Members. Part of our service focus includes toll-free access to your knowledgeable Member Services Specialists, an automated Member assistance and eligibility system, and access to our website at dentalhealthservices.com/CA to helpanswer questions about your plan and its benefits.

Family Dental Benefit Matrix

This matrix is intended to help you compare pediatric Essential Health Benefits coverage and is a summary only.

Pediatric Dental EHB Up to Age 19	
Emergency Dental Care	Please refer to the Emergency Care section of this Evidence of Coverage
Office Copay	$0
Waiting Period	None
Deductible	None
Annual Benefit Limit	None
Out-of-Pocket Maximum	Individual - $350 Family - $700
Diagnostic & Preventive Services	
Oral Exam	No Charge
Preventive-Cleaning	No Charge
Preventive X-Rays	No Charge
Sealants per Tooth	No Charge
Topical Fluoride Application	No Charge
Space Maintainers-Fixed	No Charge
Basic Services	
Restorative Procedures	$20-$310
Periodontal Maintenance	$30
Major Services	
Periodontics (other than maintenance)	$10-$350
Endodontics	$20-$365
Crowns and Casts	$65-$350
Prosthodontics	$20-$350
Oral Surgery	$30-$350
Orthodontia	
Medically Necessary Orthodontia	$350
Outpatient Services	No Additional Charge

Hospitalization Services	Not Covered
Ambulance Services	Not Covered
Prescription Drug Coverage	Not Covered
Durable Medical Equipment	Not Covered
Mental Health Services	Not Covered
Professional Services	Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments.

Adult Dental Age 19 and Older	
Emergency Dental Care	Please refer to the Emergency Care section of this Evidence of Coverage
Office Copay	$0
Waiting Period	None
Deductible	None
Annual Benefit Limit	None
Out-of-Pocket Maximum	Not Applicable
Diagnostic & Preventive Services	
Oral Exam	No Charge
Preventive-Cleaning	No Charge
Preventive X-Rays	No Charge
Sealants per Tooth	No Charge
Topical Fluoride Application	No Charge
Space Maintainers-Fixed	No Charge
Basic Services	
Restorative Procedures	$20-$310
Periodontal Maintenance	$30
Major Services	
Periodontics (other than maintenance)	$10-$350
Endodontics	$20-$365
Crowns and Casts	$165-$400

Prosthodontics	$20-$400
Oral Surgery	$35-$1,200
Orthodontia	
Medically Necessary Orthodontia	Not Covered
Outpatient Services	No Additional Charge
Hospitalization Services	Not Covered
Ambulance Services	Not Covered
Prescription Drug Coverage	Not Covered
Durable Medical Equipment	Not Covered
Mental Health Services	Not Covered
Professional Services	Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments.

Your Member Services Specialist

Please feel free to call, fax, send an email to membercare@dentalhealthservices.com, or write us anytime with questions or comments. We are ready to help you! Your Member Services Specialist can be reached through any of the following ways:

Phone: 855-495-0905, 711 (TDD/TTY)
Fax: 562-424-6088
Email: membercare@dentalhealthservices.com
Web: dentalhealthservices.com/CA
Mail: Dental Health Services
3780 Kilroy Airport Way Suite 750
Long Beach, CA 90806

Eligibility

As the Subscriber, you can enroll alone, with your spouse/domestic partner and/or with Children who areunder twenty-six (26) years of age. Members are not required to have Children to enroll in this Family Dental HMO Dental Plan through Covered California for Small Business.

Subscribers must live or work within Dental Health Services' Service Area in order to enroll in this Family Dental HMO Dental Plan. Dependents may live outside Dental Health Services' Service Area but will only receive coverage at a Dental Health Services' Participating Dentist (and Participating Specialists for Members up to age 19), except in the event of an emergency.

Members up to age 19 are eligible for pediatric coverageunder this plan until their nineteenth (19th) birthday month. At the end of their nineteenth (19th) birthday month, the Member will automatically be transferred toadult coverage. For example, if a Member's nineteenth (19th) birthday is July 15, on August 1st, the Member will automatically receive adult dental plan coverage.
There is no lapse in coverage during this time.

Adult Members will be covered for Benefits included under the adult Covered Services and Copayments section of the Schedule of Covered Services and Copayments included with this booklet. Once adult coverage is in effect, the pediatric Out-of-Pocket Maximum will no longer apply. An enrolled dependentChild who reaches ages 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the dependentChild becomes ineligible.

Eligible children are children of the Subscriber, Subscriber's spouse, or Subscriber's domestic partner. Eligible children include a biological Child; astepchild; an adopted Child; a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner assumes a legal obligation for total or partial support in anticipation of adoption; and a Child for whom the Subscriber, Subscriber's spouse, or Subscriber'sdomestic partner is the legal guardian.

Children twenty-six (26) years of age and older are onlyeligible for coverage as a Dependent while the Child is and continues to be both:

1. Incapable of self-sustaining employment byreason of a physically or mentally disabling injury, illness, or condition, and
2. Is chiefly dependent upon theSubscriber forsupport and maintenance

A family must enroll all pediatric Children in a familyfor any one Child in the family to be eligible for Benefits under this plan.

For disabled Dependent children, Dental Health Services will provide notice to the Subscriber at least 90days prior to the Dependent Child's attainment of the limiting age.

Coverage for a disabled Dependent Child will terminateupon the Dependent Child's attainment of twenty-six (26) years of age, unless proof of incapacity or dependency is provided to Dental Health Services within sixty (60) from the date the Subscriber receivedthe notice.

Dental Health Services may require ongoing proof ofthe Dependent Child's incapacity or dependency, butnot more frequently than annually after the two-year period following the Child's attainment of twenty-six (26) years of age.

Disabled Dependent Child enrolling for new coveragemay initially be required to show proof of incapacity and dependency, and then not more than annually to ensure the Dependent Child continues to meet the conditions above. Proof must be provided within sixty (60) days of such request. Failure to do so may result in termination of your Dependent Child's eligibility.

The disabled Dependent Child must have been enrolled as adependent under the Subscriber or spouse/domestic partner under a previous dental plan at the time the Dependent Child reached the limiting age.

Enrollment

This is a Qualified Dental Plan offered exclusively through Covered California. Qualified Dental Plans expire each calendar year. Enrollment rates are valid forthe calendar year or until terminated according to the procedures contained in this booklet.

Administration of these plan designs must comply with requirements of the Pediatric Dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in theEarly Periodic Screening, Diagnosis, and Treatment(EPSDT) benefit.

The requirement set forth in 10 CCR 6522 (a)(4)(A) and(a)(5)(A) shall apply to this Covered California for SmallBusiness dental plan design.

Dependents must be added at the time of initialenrollment or during open enrollment.

If you experience a qualifying event, you may be eligible for a sixty (60) day Special

Enrollment Period. You mustreport this event within sixty (60) days of the event to Covered California through their web portal at coveredca.com for consideration of a sixty (60) day Special Enrollment Period. In the case of birth, adoption,or placement for adoption, you have sixty (60) days to report the event to Covered California through their web portal. California may grant you a Special Enrollment Period due to one of the follow circumstances:

1. A qualified individual or dependent loses minimum essential dental health benefits. (This excludes loss of coverage due to non-payment.)

2. A qualified individual gains a dependent orbecomes a dependent through marriage/domestic partnership, birth, adoption, or placement for adoption.

3. An individual who previously was nota citizenof the United States is granted citizenship.

4. Enrollment or non-enrollment in Covered California is erroneous and/or unintentional as a result of an error made by either HHS orCovered California.

5. An individual is able to adequately demonstrate to Covered California that the individual's current Qualified Dental Plan substantially violated material provisions of the existing agreement between the individualand the Qualified Dental Plan.

6. An individual becomes eligible or ineligible for advance payment of the premium tax credit or change in eligibility for cost sharingreductions.

7. A permanent move to a new area has giventhe individual access to a new Qualified Dental Plan;

8. An individual is a member of a federally recognized American Indian or Alaska NativeTribe. Individuals may enroll in or change Qualified Dental Plans one time each month.

9. An individual whose existing coverage through an eligible employer-sponsored planwill no longer be affordable or provide minimum value; and

10. An individual demonstrates to Covered California that in accordance with guidelinesprovided by HHS the individual meets otherexceptional circumstances as Covered California may provide.

For complete detailed enrollment provisions set forthby Covered California in accordance with the guidelines provided by HHS, please go to coveredca.com.

Coverage Effective Dates

Coverage effective dates are determined during yourapplication and enrollment with Covered California and can be affected by any medical policy you purchased.

Your Dental Health Services coverage will begin once the enrollment process is complete, premium payment is received and the effective date is communicated to Dental Health Services by CoveredCalifornia.

Your Dental Health Services Member Services Specialists are ready to assist you in communicating with Covered California. Please contact us at 855-495-0905 or connect with us at dentalhealthservices.com/CA.

Loss of Medi-Cal or Job-Based Coverage:

If you experience loss of Medi-Cal or job-based coverage, and use a Special Enrollment Period, coverage would begin on the first day of the next month following your plan selection, regardless ofthe date during the month you select coverage.

New Dependent Additions

New dependent enrollments are subject to the rules established by Covered California. Enrollment requests for newly acquired Dependents must be submitted to Covered California in a timely manner,according to their policies and procedures. Covered California will determine the effective date of the Dependent's plan according to the effective date theenrollment request was submitted.

Newborn and Adoptive Children

A newborn, or a Child placed for adoption is eligible from the moment of birth or placement. You must apply through Covered California to enroll your new Dependent. If enrollment is not completed according tothe rules established by Covered California, the new Dependent will be effective according to the open enrollment rules established by Covered California.

Dependent Additions Due to Marriage

The effective date for Dependents acquired through marriage will be the first day of the month following your plan selection submitted to Covered California regardless of when during the month you make your plan selection. If enrollment is not completed according to the rules established by Covered California, the new Dependent will be effective according to the open enrollment rules established by Covered California.

On a Case-by-Case Basis

Covered California may start coverage earlier on acase-by-case basis.

Your Participating Dentist

Service begins with the selection of local, independently owned, Quality Assured[sm] dental offices. Professional skill, commitment to preventionand wellness, convenience of location and flexibility in appointment scheduling are some of the most important criteria involved in approving a Participating Primary Dentist.

The ongoing Member care at each dental office ismonitored regularly through our rigorous QualityAssurance[sm] standards.

Your First Dental Appointment

Your initial appointment is an opportunity for you tomeet your Participating Dentist. Your dentist will complete an oral examination and formulate a treatment plan for you based on their clinical assessment of your oral health.

Your initial exam may require a Copayment and you may need additional diagnostic services such asperiodontal charting or x-rays. You may also be charged Copayments for additional services as necessary.

After your initial visit, you may schedule an appointment for future care, such as cleanings, to complete your treatment plan. Cross-reference yourtreatment plan with your Schedule of Covered Services and Copayments to determine the Copayments for your scheduled procedures. Copayments are due in full at the time services are performed

Quality Assurance

We're confident about the care you'll receive because our Participating Dentists meet and exceed the highest standards of care demanded by our Quality Assurance[sm] program. Before we contract with any dentists, we visit their offices to make sure your needswill be met. Dental Health Services' Professional Services Specialists regularly meet and work with our Participating Primary Dentists to maintain excellence in dental care.

Timely Access to Care

Upon enrolling in Dental Health Services' Family Dental HMO plan, a Participating Primary Dentist should be selected from our Covered California plan network of Quality Assured Participating Dentists. Tosearch for Participating Dentists online,

visit Dental Health Services' website at dentalhealthservices.com/CA or through coveredca.com.

If you prefer a printed directory, please call 855-495-0905 and a directory will be mailed to you.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears in the online directory, or in the printed Directory of Quality Assured Participating Dentists and request an appointment. Routine, non-emergency appointmentswill be scheduled within a reasonable time period; nomore than three weeks.

You are only eligible for services at Dental Health Services' Participating Primary Dentists (and Participating Specialist office for Members up to agenineteen (19). Pre-authorization from Dental Health Services is required for services provided by a Participating Specialist), except in an emergency situation or when pre-authorized by Dental HealthServices.

Each dental office is independently owned and establishes its own policies, procedures, and hours. Ifyou need to cancel your appointment, please call yourdental office at least twenty-four (24) hours prior to your scheduled appointment time. A penalty may be assessed if your dental appointment is canceled with less than twenty-four (24) hours' notice. For your Participating Dentist's appointment cancellation policy and procedures, please contact the dentist office directly.

Dentist Access Standards – PrimaryDentists

Dental Health Services strives to ensure you have access to a Quality Assured ParticipatingPrimary Dentist close to your home or business. We have established availability standards based on whether plan Members reside or work in urban, suburban, rural or mountain areas.

If you are not able to locate a Participating Primary Dentist, please contact Member Services at 855-495-0905. We're happy to assist you in finding a Quality Assured Dentist close to you that falls within Dental Health Services' access standards. If no dentist is available who meets Dental HealthServices' access standards, out-of-area accessmay be authorized. In the event of an emergency, please see the Emergency Care section for guidelines.

Dentist Access Standards –Participating Specialists

As a Dental Health Services Member, you have access to over 2,000 Quality Assured Participating Specialists, including orthodontists, oral surgeons, endodontists, pediatric dentists, and periodontists. You mayreceive care from any Participating Specialist with a referral from your Primary Dentist. For more information about Dental Health Services' referral process, please refer to the Pre- Authorization

Submission section of thisbooklet.

If access to a Participating Specialist is not within reasonable proximity of your business or residence, Dental Health Services will workwith your Participating Primary Dentist to authorize out-of-area access. In addition, Dental Health Services will seek recruitment of specialists who meet our Quality AssuranceStandards and are close to you. In the event ofan emergency, please see the Emergency Care section for guidelines.

Emergency Care

If you have a medical emergency, receive careimmediately by calling 911 or by going to the nearest hospital emergency room. You are covered for dental emergencies at all times both inside and outside of Dental Health Services' Service Area.
Pre-authorization is not required to receivepalliative emergency treatment.
Palliative Care is treatment to relieve pain or alleviate a symptom without dealing with the underlying cause. Palliative Care for Emergency Dental Conditions in which acutepain, bleeding, or dental infection exist, is a benefit according to your Schedule of Covered Services and Copayments.
If you have a dental emergency and need immediate care, please follow the steps below:

1. Call your selected Participating Dentist.

   Dental offices maintain twenty-four (24) houremergency communication accessibility and are expected to see you within twenty-four (24) hours of initial contact or within a lesserperiod of time as may be medically necessary.

2. If your Participating Dentist is not available,call your Member Services Specialist at 855-494-0905, 711 (TDD/TTY).

   Your Member Services Specialist will assist you in scheduling an emergency dental appointment with another Quality Assured[sm]dentist in your area.

3. If you are out of Dental Health Services' Service Area or both Dental Health Services and a Participating Dentist cannot be reached,seek emergency palliative treatment from any licensed dentist practicing in the scope of their license.

   Dental Health Services requires that after receiving treatment of an Emergency Dental Condition, the covered patient be transferredto a Participating Dentist's office for post- Emergency Dental Condition treatment.
   Follow-up care that is a direct result of the emergency must be obtained within Dental Health Services' usual terms and conditions ofcoverage.

4. You will only be responsible for applicableCopayments for emergency treatment when services are provided by a Participating Dentist.

   When services are provided by an Out-of- Network Dentist, you will be responsible forthe entire bill. Dental Health Services will then reimburse you up to $50 per occurrencefor the cost of emergency care beyond your applicable Copayment(s)for dental work done to eliminate pain, swelling, or bleeding.

   To be reimbursed for any amount over the applicable emergency Copayments, you must submit the itemized dental bill from the dentaloffice that provided the emergency services with a brief explanation, and your Member number to Dental Health Services within one hundred eighty (180) days of the date the dental treatment was rendered to:

Dental Health Services Attn: Claims Department
3780 Kilroy Airport Way, Suite 750Long Beach, CA 90806

If you do not submit this information within one hundred eighty (180) days, Dental HealthServices reserves the right to refuse payment.

If services for the treatment of an EmergencyDental Condition are authorized by any employee of Dental Health Services, we may not deny the responsibility of Member reimbursement beyond all applicable Copayments, unless approval was based on misrepresentation about the covered Member's condition made by the dentist performing the emergency treatment.

Urgent Care

Urgent Care includes conditions that do notnecessarily require immediate attention, but should be taken care of as soon as possible,such as lost or cracked fillings, or a broken tooth or crown.
Urgent Care situations should be taken care ofwithin seventy-two (72) hours. If an urgent dental situation occurs, please contact your Participating Primary Dentist or Member Services Specialists at 855-495-0905 for an urgent referral.

Teledentistry

Dental Health Services provides coverage for services appropriately delivered through teledentistry services on the same basis and tothe same extent that Dental Health Services is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

Working with Your Dentist

PLEASE READ THE FOLLOWING INFORMATION SO YOU KNOW FROM WHOM OR WHAT GROUP OF DENTISTS YOUR DENTAL CARE MAY BE OBTAINED.

Covered services must be provided by your Designated Participating Primary Dentist except inan emergency situation or when pre-authorized byDental Health Services. Dental Health Services values its Members and Participating Dentists. Providing an environment that encourages healthy relationships between Members and their dentists helps to ensure the stability and quality of your dentalplan.

Participating Dentists are responsible for providing dental advice or treatment independently, and withoutinterference, from Dental Health Services or any affiliated agents. If a satisfactory relationship cannot be established between Members and their Designated Participating Primary Dentist, Dental Health Services, the Member, or the Participating Dentist reserves the right to request the Member's affiliation with the dental office be terminated.

Any request to terminate a specific Member/dentist relationship should be submitted to Dental Health Services and shall be effective the first day of the month following receipt of the request. Dental Health Services will always put forth its best effort toswiftly place the Member with another Participating Dentist.

Changing Dental Offices

If you wish to change Primary Dentists, you must notifyDental Health Services. Requests can be made by callingyour Member Services Specialist at 855- 495-0905, x711 (TDD/TTY) or by sending a fax to 562-424- 6088. Online requests can be done through our website at dentalhealthservices.com/CA.

Requests made by the twentieth (20th) of the currentmonth become effective the first (1st) day of the following month. Changes made after the twentieth (20th) of the month become effective the first (1st) day of the second month following receipt of your request. For example, if you request to change your dentist on orbefore August 20th, your new dentist selection will become effective September 1st. If you make your dentist change request on or after August 21st, your dentist change request will become effective October 1st.

Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you tobe seen by another Participating Primary Dentist or Out-of-Network Dentist if necessary.

Arrangements will be made within five (5) days forroutine second opinions, within seventy-two (72) hours for serious conditions, and immediately for emergencies.

You should bring your x-rays to this consultation. If no x-rays are necessary, you will

pay only your officevisit and second opinion Copayments.

After you receive your second opinion, you may return to your initial Designated Participating Dentist's office for treatment. If, however, you wishto select a new Participating Primary Dentist you must contact Dental Health Services directly, either by phone in writing, by fax, or online before proceeding with your treatment plan.

Treatment Authorization

Dental Health Services works closely with our Participating Dentists to deliver quality dental care and to protect our Members. Authorization and utilization management specialists verify eligibility, authorize services, and facilitate the delivery of dentalcare to Members. Services are authorized based on the Benefits, Limitations, and Exclusions listed in each plan's Evidence of Coverage booklet.

Specialty services, if covered by your plan, require pre-authorization by Dental Health Services. The pre- authorization should be requested by your Participating Primary Dentist. Your treatment is approved and rendered according to your planBenefits. If treatment authorization is denied, you have the right to Appeal the Adverse Determination through the Grievance process.

Authorization, Modification, orDenial of Services

Dental Health Services does not make authorization decisions based on medical necessity. Decisions to approve,delay, modify, or deny care, are based on the following criteria:

- Member eligibility for services.
- Benefits are a covered service of the Member's plan.
- Dentists selected to provide services are in- networkor are approved out-of-network providers.
- Status of any applicable maximums.
- Requested submission of necessary clinicaldocumentation.
- Submission of proper procedure coding.
- Accurate submission of referral as explained in theProvider Manual.

If Dental Health Services is unable to complete a re- view within the required time frame, it will immediately, upon the expiration of the required time frame or as soon as theplan becomes aware that it will not meet the time frame, whichever occurs first, notify the dentist and Member in writing:

- That we are unable to make the decision within the required time frame because the plan does not haveall reasonably necessary information requested

or requires an expert consultation or additional examination

- What specific information has been requested butnot received, or any additional examination or testrequired, or specifying the expert reviewer to be consulted; and

- Of the anticipated date when a decision will bemade (notice to Member only).

Concurrent care will not be discontinued until the provider has been notified of the decision and a planof care has been agreed upon for the Member.

Pre-authorization is not required for emergency or urgent services. Please see the Timely Access to Caresections, Emergency Care and Urgent Care sections in this document for specifics.

Your Financial Responsibility

You are responsible to your Participating Dentist forCopayments and incidental broken appointment penalties or interest charges. Please be aware that youare also liable for any other amounts owed for non- covered services provided by a Participating Dentist or Out-of-Network Dentist that Dental Health Services did not pre-approve for payment. All dental treatment Copayments are to be paid at the time of service directly to your Participating Dentist office.
You are not liable for any sums owed by DentalHealth Services to a Participating Dentist.

Please refer to your Schedule of Covered Services andCopayments for the benefits specific to your dental plan.

As stated under the Emergency Care section of this booklet, for services rendered by an Out-of-NetworkDentist, Dental Health Services will reimburse up to
$50 per occurrence for the cost of emergency carebeyond your Copayment. You are responsible for any other costs.

Exclusions and Limitations

This Evidence of Coverage describes your dentalplan Benefits. It is the responsibility of the Members to review this booklet carefully and to be aware of its Exclusions and Limitations of Benefits.

Please reference the Exclusions and Limitations of Coverage described in your Schedule of Covered Services and Copayments included with this booklet.Procedures described in the Exclusions and Limitations of Coverage section are considered non-covered services even if they are medically necessaryor are recommended by a dentist.

Pediatric Dental services apply to Members up to age19.

Out-of-Pocket Maximum(OOPM)

Out-of-Pocket Maximum (OOPM) is the total amount of Copayments you'll need to pay on your own before your plan benefits are paid in full for theplan year. Once you've met the Out-of-Pocket Maximum for a plan year, you will not be required to pay further Essential Health Benefit Copayments forcovered dental services under your Dental Health Services plan for the remainder of the plan year.
Please see the definitions section of this booklet for a full description of Out-of-Pocket Maximum.

OOPM applies only to the Essential Health Benefits or Pediatric Age (up to age 19) Members. Member's who have a deductible and/or an out-of-pocket maximum may request their deductible and/or out-of-pocket maximum accrual balance at any time by calling DHS at 800-223-4347.

Accrual updates will be mailed to the member for every month in which benefits were used and until used and until the accrual balance equals the full OOPM, unless the member has elected to opt-out of mailings. Members may opt-in or opt-out of receiving mailed notices, and elect to receive their accrual update electronically, at any time by calling the Plan at 800-223-4347.
Essential Health Benefit Copayments for covered services received from your Participating Dentist accumulate through the plan year toward your Out- of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes premium, prescriptions, or dental care your dental plan doesn't cover. After the Pediatric Age Member meets their OOPM, they will have no furtherCopayments for Essential Health Benefits services forthe remainder of the plan year.

For families with more than one Pediatric Age Member, Copayments made by each individual Childfor Essential Health Benefits services contribute to the family Out-of-Pocket Maximum. Once the Copayments paid by all Pediatric Age Member for Essential Health Benefits services meets the family Out-of-Pocket Maximum, no further Copayments for Essential Health Benefits services will be required by any of the pediatric age Members for theremainder of the plan year.
Dental Health Services monitors your out-of-pocketcopayments over the course of your plan year.
When your copayments reach the Out-of-Pocket Maximum for your plan, we will send a letter to both you and your Designated Participating PrimaryDentist to ensure that you are not responsible for Essential Health Benefit Copayments for the remaining plan year.

You are encouraged to track your out-of-pocket expenses by retaining receipts for all of the covered services you receive under your Dental Health Services plan through the plan year. Never hesitate to ask your Participating Dentist for an itemized receipt for services provided during your visit.

Your Financial Responsibility for Non-Covered Services

You will be liable for the cost of non-covered servicesperformed by a Participating Dentist and for any services performed by an Out-of-Network Dentist that Dental Health Services does not pre-approve for payment. You are not liable for any sums owed by Dental Health Services to a Participating Dentist.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Participating Dentist may charge you their Usual, Customary, and Reasonable rate for those services. Prior to providing a patient with dental services that are not a covered benefit, 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 your Member Services Specialist at 855-495-0905.To fully understand your coverage, you may wish to carefully review this Evidence of Coverage booklet.

Optional Treatment

If you choose a more expensive elective treatment inlieu of a covered benefit, the elective treatment is considered optional. You are responsible for the cost difference between the covered and Optional Treatment on a fee-for-service basis. If you have anyquestions about Optional Treatment or services you are asked to pay additional for, please contact your Member Services Specialist before you begin servicesor sign any agreements.

Covered California – Coordination of Benefits

Covered California's standard benefit design requiresthat stand alone dental plans offering the Pediatric Dental Benefit, such as this Dental Health Services plan, whether as a separate benefit or combined witha family dental benefit, cover benefits as a secondarypayer.

When your primary dental benefit plan is coordinating its benefits with Dental Health Services,your primary dental benefit plan will pay the maximum amount required by its plan contract with you.

This means that when a primary dental benefits planis coordinating benefits with your Dental Health Services plan, Dental Health Services will pay the lesser of either the amount that it would have paid inthe absence of any other dental benefit coverage, or your total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under your Dental Health Services plan.

Quality remains the utmost concern at Dental HealthServices. If you are wishing to coordinate coverage with your primary dental benefits carrier, please call your Member Services Specialist at 855-495-0905.

Your Participating Dentist submits Utilization and Encounter Forms for services provided on a monthlybasis. Submission of these reports allows Dental Health Services to both monitor your treatment, and ensure supplement payments, when appropriate, are made to your Participating Dentist. Claims for pre- authorized specialty services are submitted by your Participating Specialist to Dental Health Services for processing and payment.

Specialty Care Coverageand Pre-authorization

All plans include specialty care coverage.

All treatment received from Participating Specialistsmust be pre-authorized.

When pre-authorized by Dental Health Services, you will never be required to pay more than your Copayment amount. Plan Members are referred to a Participating Specialist if one is available in your area. In cases where there is no Participating Specialist in your area, Dental Health Services will arrange for carewith an Out-of-Network Specialist at no additional cost to you.

Pre-Authorization for Specialty Care

In order to see a Dental Health Services Participating Specialist, you must first be referred by your Designated Participating Primary Dentist. Dental Health Services will review the request for pre-authorization and notify the Participating Dentist and Participating Specialist of the pre-authorized services.

Pre-Authorization Submission

Your Participating Dentist or Participating Specialist will submit a pre-authorization request for your services. You, your Participating Dentist, and your assigned Participating Specialist will be notified whether your pre-authorization is approved ordenied within five (5) business days of Dental Health Services receiving the request. This five (5) day period may be extended one (1) time, for up to an additional fifteen (15) days, provided such extension is necessary due to circumstances beyond Dental Health Services'control. If an extension is necessary, Dental Health Services will notify you and the referring Participating Primary Dentist/Specialist of the circumstances requiring this extension within five (5) days ofreceiving the request.

If your request for pre-authorization is not submitted according to the procedures outlined in this booklet, you and the referring ParticipatingPrimary Dentist/Specialist will be notified of the procedural failure and the proper procedures to be followed in submitting your request withinfive (5) days following Dental Health Services' discovery of any procedural error. Notification may be oral, written, or electronic.

Adverse Determinations

If all or part of the claim for your services isdenied, Dental Health Services will notify you in writing of this Adverse Determination. The notification will includethe actual reason(s) for the determination, and the instructions for obtaining an Appealof the decision through the Grievance process.

If you wish to Appeal the Adverse Determination of your Urgent Care pre-authorization, a decision regarding your Appeal will be made within seventy-two (72) hours. The result of your Appeal will be communicated to you by phone/oral notification as well as written or electronic communication.

Continuity of Care

If you are in the middle of treatment and your currentDesignated Participating Primary Dentist is terminated or you are joining Dental Health Services as a new Member, you may have the right to keep your current dentist for a designated period of time.

Please contact your Member Services Specialist at 855-495-0905 or www.dentalhealthservices.com/CAfor assistance and to request a copy of Dental HealthServices' Continuity of Care Policy.

New Members: You may request continuation of covered services for certain qualifying conditions from your Out-of-Network Dentist. Your request must be made within thirty (30) days of enrolling. If agood cause exists, an exception to the thirty (30) day time limit will be considered. Dental Health Services,at the request of a Member, will provide the completion of covered services for treatment of certain qualifying conditions if the covered services were being provided by an Out-of-Network Dentist to a newly covered Member at the time their coverage became effective. If you currently have coverage with Dental Health Services and are switching to a different Dental Health Services plan, please see the following section.

Current Members: You may request continuation ofcovered services for certain qualifying conditions from your Participating Dentist in the event that the provider's contract is terminated. Dental Health Services, at the request of a Member, will provide thecompletion of covered services for treatment of qualifying conditions if the services are provided by adental office that is no longer contracted with Dental Health Services. Your request must be made within thirty (30) days of enrolling. If a good cause exists, anexception to the thirty (30) day time limit will be considered.

Qualifying Conditions: The Member has a right to complete covered services if their condition falls within one of the qualifying categories listed below:

- Completion of covered services shall be provided for the duration of an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires promptmedicalattention and has a limited duration.
- Completion of covered services for a Memberwho is a newborn Child

between birth and age thirty-six (36) months, not to exceed twelve (12) months from the contract termination date for current Members or twelve (12) months from the effective date ofcoverage for a newly covered Member.

- Performance of a surgical or other procedure that is authorized by the plan as part of a documented course of treatment and has beenrecommended and documented by the dentistto occur within one hundred eighty (180) daysof the provider's contract termination for

  current Members or one hundred eighty (180)days from the effective date of coverage for newly covered Members.

All services are subject to Dental Health Services' consent and approval, and agreement by the terminated dentist, consistent with good professional practice. You must make a specific request to continueunder the care of your current dental provider. Dental Health Services is not required to continue your care with the dentist if you are not eligible under our policyor if we cannot reach agreement with the dentist on the terms regarding your care in accordance with California law. If you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 888-466-2219, at a TDD number for the hearing impaired at 877-688-9891, or online at www.dmhc.ca.gov.

Termination of Coverage

Covered California determines eligibility and continued eligibility for coverage. Members are required to give at least fourteen (14) daysnotice when choosing to end coverage beforethe end of the policy term. This notice can beprovided to Dental Health Services or Covered California.

Upon cancelling any Member's dental Benefits plan, Dental Health Services shall notify the Subscriber in writing of the reason(s) for canceling the coverage, by mail,at least thirty (30) days prior to canceling their coverage.

Coverage of an individual Subscriber and their Dependents may be terminated for anyof the following reasons:

1. Failure of the Subscriber to make premium payments in a timely manner.(See Termination Due to Nonpayment).
2. Material misrepresentation (fraud) inobtaining coverage.
3. The Member relocates outside of the state of California or outside of Dental Health Services' Service Area.

See the Termination of Benefits for Nonpaymentsection of this document for specific details abouttermination due to unpaid premiums.

Coverage for the Subscriber and their Dependents will terminate at of the end of the

month during which the Subscriber leaves the employment of the group or otherwise ceases to be eligible for coverage,except for any of the reasons above, when termination may be mid-month.

Notice will be given by Dental Health Services to thesubscriber at least 15 days prior to canceling the coverage or the group representative will provide adequate notice of termination to the Subscriber. In the event coverage is terminated, the Subscriber shallbecome liable for charges resulting from treatment received after termination. If you lose eligibility, you may qualify for continuing coverage through COBRA (see Individual Continuation of Benefits) orspecial enrollment through Covered California (see Special Enrollments).

Termination of Coverage by Member

A Member may terminate their coverage by contactingCovered California or Dental Health Services. If you wish to cancel your dental Benefits, please contact us at 855-495-0905 and your Member Services Specialistwill facilitate your contact with Covered California.

The Member may cancel their plan through the Covered California web portal under the followingcircumstances:

1. If a member obtains other essential dental healthbenefits through another qualified dental plan during an open enrollment or Special EnrollmentPeriod.

2. Death of the Member. In the event of cancellation due to death, the cancellation date will be the date the event occurred.

Termination of Coverage Due to Non-Payment

Benefits under this plan depend on premium payments being current. Dental Health Services willissue a notice of termination to the Subscriber, employer, or contract holder for non-payment.

Dental Health Services will provide you a thirty (30) day grace period, which begins after the last day of paid coverage. Although you will continue to be covered during this thirty (30) day grace period, you will be financially responsible for the premium for thecoverage provided during the thirty (30) day grace period.

During the thirty (30) day grace period, you can avoidcancellation or non-renewal by paying the premium you owe to Dental Health Services. If you do not paythe premium by the end of the thirty (30) day grace period, your coverage will be terminated at the end ofthe thirty (30) day grace period. You will still be legally responsible for any unpaid premiums you oweto Dental Health Services.

Any service(s) then "in progress" must be completed within the thirty (30) day grace period, with the Member's cooperation. The Member is responsible for any scheduled Copayments, if any. We encourage you to make individual arrangements

with your dentist for continuation of diagnosed services if Benefits are terminated.

Individual Continuation of Benefits

Continuation of Coverage COBRA Benefits Consolidated Omnibus Budget Reconciliation Act(COBRA)

Federal Cobra

COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.

It is the sole responsibility of the group to determine compliance and eligibility under COBRA (Federal), aswell as to administer all notification requirements andpremium collection functions associated with and required by the Act.

COBRA may allow subscribers and their enrolled dependents to keep coverage for up to 18 or 36 months,depending on qualifying events and other circumstances.

Each qualified person may independently enroll in COBRA. A parent or legal guardian may elect COBRAfor a minor Child.

COBRA participants will receive the same dental benefits as current employees enrolled in a DentalHealth Services' plan.

Important deadlines for electing/ enrolling in COBRA coverage with Dental Health Services

Employer Deadlines:

1. Notification of Qualifying Event - Employer must notify Dental Health Services within thirty (30) days ofthe following qualifying events:

- Employee's termination of benefits
- Employee's hours are reduced
- Employee becomes eligible for Medicare benefits
- Death of employee

Employee Deadlines:

COBRA enrollees must notify the group and DentalHealth Services within sixty (60) days after any of thefollowing qualifying events:

1. Employee divorces or legally separates

2. A Child or other dependent no longer qualifies asa dependent under the plan rules

Notifications:

Election Notice: Generally, the group must send an election notice no later than 14 days after Dental Health Services has been notified that a qualifyingevent has occurred.

Election Period: The employee has 60 days to notify Dental Health Services in writing that the employeewants to elect /enroll in COBRA coverage. The 60 days starts on the later of the following two dates:

1. The date the employee receives the election notice
2. The date coverage ended

Premium Payment:

The first COBRA premiums must be received by Dental Health Services within 45 days after COBRA is elected. The first premium will cover the time period between the employee's loss of coverage due to a qualifying event up to the day of COBRA enrollment. COBRA premiums will continue monthlyas long as COBRA coverage is continued.

The employee will lose COBRA coverage if:

- Premium payments are not made on time
- Employee moves outside of Dental Health Services'Service Area
- Group terminates group dental plan with DentalHealth Services
- Former employee becomes Medicaid eligible
- Employee enrolls in another dental plan
- Employee commits fraud, which means the formeremployee intentionally deceived Dental Health

Services or misrepresented themselves or allowed someone else to do so in order to get dental services.

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA)toll free at 866-444-3272.

Cal-COBRA

THE CALIFORNIA CONTINUATIONBENEFITS REPLACEMENT ACT

U.S. and California laws protect your right and your dependents' right to continue your health coverage under certain circumstances or qualifying events. Thisis called continuation health coverage or continuationof benefits.

The California Continuation Benefits Replacement Act (Cal-Cobra) became effective on January 1, 1998.Cal-COBRA is a California law that is similar to Federal COBRA. Unlike Federal COBRA, Cal- COBRA requires that Dental Health Services provide continuation of coverage for employer groups which employ 2 to 19 employees on at least 50% of its working days during the preceding calendar year.

Like Federal COBRA, employees become eligible for Cal-COBRA once they experience a loss of coverage due to a qualifying event.

Qualifying events for Cal-COBRA include:

a. Death of an employee

b. Termination of Employment (other thangross misconduct)

c. Reduction in hours

d. Divorce or legal separation of a coveredspouse from a covered employee

e. Dependent ceases to be eligible as a dependent

f. Covered employee's eligibility of coverageunder Medicare

Upon a qualified beneficiary's exhaustion of federal COBRA, typically the qualified beneficiary would be eligible to continue their coverage through Cal- COBRA for an additional 18 months, not to exceed atotal of 36 months. Because Dental Health Services isa specialized health care service plan, offering dental-only plans, qualified beneficiaries are not able to continue their coverage upon exhaustion of federal COBRA under Cal-COBRA through Dental Health Services. Dental only plans are excluded from offering the eighteen (18)-month extension afterCOBRA through Cal-COBRA.

Each qualified person may independently enroll inCal-COBRA. A parent or legal guardian may electCal-COBRA for a minor Child.

Cal-COBRA participants will receive the same dentalbenefits as current employees enrolled in a Dental Health Services' plan.

Important deadlines for electing/enrolling inCal-COBRA coverage with Dental Health Services

Employer Deadlines:

1. Notification of Qualifying Event - The employer must notify Dental Health Services within thirty (30)days of the following qualifying events:
    a. Employee's termination of benefits
    b. Employee's hours are reduced

Employee Deadlines:

Cal-COBRA enrollees must notify Dental HealthServices within sixty (60) days after any of the following qualifying events:

a. Death of employee
b. Employee divorces or legally separates
c. A Child or other dependent no longer qualifiesas a dependent under the plan rules
d. Employee becomes eligible for Medicare benefits

Notifications:

Election Notice: Dental Health Services will send an election notice no later than fourteen (14) days afterDental Health Services has been notified that a qualifying event has occurred.

Election Period: The employee has sixty (60) days to notify Dental Health Services in writing that employee wants to elect/enroll in Cal-COBRA coverage. The sixty (60) days starts on the later of thefollowing two dates:

a. The date the employee receives the election notice
b. The date coverage ended

Premium Payment:

The first Cal-COBRA premiums must be received byDental Health Services within forty-five (45) days after Cal-COBRA is elected. The first premium will cover the time period between the employee's loss ofcoverage due to a qualifying event up to the day of Cal-COBRA enrollment. Cal-COBRA premiums willcontinue monthly as long as Cal-COBRA coverage iscontinued.

Employee will lose Cal-COBRA coverage if:

a. Premiums payments are not made on time

b. Employee moves outside of Dental HealthServices' Service Area

c. Group terminates group dental plan with DentalHealth Services

d. Former employee becomes Medicaid eligible

e. Employee enrolls in another dental plan

f. Employee commits fraud, which means the formeremployee intentionally deceived Dental Health Services or misrepresented themselves or allowed someone else to do so in order to get dental services.

Re-enrollment

Re-enrollment will be facilitated through Covered California according to the terms and conditions thereunder. All payments due must be satisfied priorto re-enrollment. Please go to Covered California foradditional information regarding your re-enrollment rights and processes.

Grievance Process

A Grievance is a written or oral expression of your dissatisfaction regarding Dental Health Services and/or a Participating Dentist, including your concerns about quality of care. Complaints, disputes,requests for reconsideration or Appeal made by you or someone who is authorized to represent you on your behalf are all considered Grievances.

Dental Health Services can assist you with working out any issues you may have with a Participating Dentist or your plan. For assistance, you may contactyour Member Services Specialist by calling 855-495- 0905, mailing a letter to Member Services, Dental Health Services, 3780 Kilroy Airport Way, Suite 750,Long Beach, CA 90806, or by emailing membersatisfactionteam@dentalhealthservices.com.

You have one hundred-eighty (180) calendar days following any incident or action that is the subject ofyour dissatisfaction to file your Grievance.
Grievances are acknowledged by Dental Health Services in writing within five (5) days of receipt. Every effort will be made by Dental Health Services to resolve Grievances within thirty (30) business daysof receiving the Grievance or notification. Urgent Grievances are addressed immediately and respondedto in writing within three (3) calendar days. Should you be unhappy with the decision, you may request a review by notifying Dental Health Services in writing.

Voluntary mediation is available by submitting a request to Dental Health Services. In cases of extreme hardship, Dental Health Services may assumea portion or all of a Member's or Subscriber's share of the fees and expenses of the neutralarbitrator.

If you choose to dispute an Adverse Determination ofa pre-authorization or a claim for a procedure that hasbeen denied, modified, or delayed in whole or in part due to a finding that the service is not Medically Necessary, you may seek an Independent Medical Review with the Department of Managed Health Carewithin 180 days of exhausting the Grievance process.

The following is the exact language and notice as required by the DMHC (Department of Managed Health Care) and it is important to note that, althoughthis refers to "Health Plans," it also includes your dental plan.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at **855-495-0905** and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for morethan thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments thatare experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Cancellation Grievance Process

If you believe your Plan coverage or contract has been or will be improperly canceled, rescinded, or not renewed; you have at least 180 days from notice of cancellation to file a grievance with Dental HealthServices or the Department of Managed Health Care.

Dental Health Services will treat such a grievance asan 'urgent grievance' providing you and the DMHCwith an acknowledgement within three (3) calendar days of the receipt of such a grievance.

If the DMHC determines a proper grievance exists, the DMHC will notify Dental Health Services withintwo (2) business days that the complaint is a proper grievance. Within one (1) business day of the receiptof this notice from the DMHC, Dental Health Services shall provide a copy of all information usedto make its coverage cancellation decision with the DMHC.

The DMHC will deliver their final determination toyou and Dental Health Services within thirty (30) calendar days or at their discretion

Public Policy Committee

As a Member of Dental Health Services, your concerns about benefits and services that Dental Health Services offers are important to us. Dental Health Services' Public Policy Committee reviews Member needs and concerns and recommends improvements to the Plan. You are invited to participate in the Public Policy Committee. If you areinterested in membership of the committee or wouldlike to comment, send your request in writing to the Public Policy Committee Coordinator, Dental HealthServices, 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806.

Organ Donation

Dental Health Services is committed to promoting the life-saving practice of organ donation. We encourage all of our Members to give the gift of life by choosing to become organ donors. Valuable information on organ donation and related health issues can be found on the Internet at www.organdonor.gov or by visiting your local DMVoffice for a donor card.

Your Privacy & Confidentiality Notice – California

Dental Health Services, Inc. is required by law to maintain the privacy and security of your protected health information. This notice describes how your medical and dental information may be used and disclosed and how you can access and control your information. Please review it carefully. This notice is updated effective March 1, 2022.

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information. We do not sell Member information. Your personal information will not be disclosed to nonaffiliated third parties, unless permitted or required by law, or authorized in writing by you.

Throughout this notice, unless otherwise stated, your medical and dental health information refers only to information created or received by Dental Health Services and identified as Protected Health Information (PHI). Examples of PHI include your name, address, phone number, email address, birthdate, treatment dates and records, enrollment and claims information. Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional circumstances.

Under what circumstances must Dental Health Services share my PHI?

Dental Health Services is required to disclose your PHI to you, and to the U.S. Department of Health and Human Services (HHS) when it is conducting an investigation of compliance with legal requirements. Dental Health Services is also required to disclose your PHI, subject to certain requirements and limitations, if the disclosure is compelled by any of the following:

- A court order or subpoena.
- A board, commission, or administrative agency pursuant to its lawful authority.
- An arbitrator or panel of arbitrators in a lawfully requested arbitration.
- A search warrant.
- A coroner in the course of an investigation; or by other law.

When may Dental Health Services disclose my PHI without my authorization?

- Dental Health Services is permitted by law to use and disclose your PHI, without your authorization, for purposes of treatment, payment, and health care administration.

- Treatment purposes include disclosures related to facilitating your dental care.

- Payment purposes include activities to collect premiums, to determine or maintain coverage and related data processing, including pre-authorization for certain dental services.

- Health Care Administration means basic activities essential to Dental Health Services' function as a Limited Health Care Service Contractor, and includes reviewing the qualifications, competence, and service quality of your dental care provider; and providing referrals for specialists.

- In some situations, Dental Health Services is permitted to use and disclose your PHI without your authorization, subject to limitations imposed by law. These situations include, but are not limited to:

    - Preventing or reducing a serious threat to the public's health or safety.
    - Concerning victims of abuse, neglect, or domestic violence
    - Health oversight agency.
    - Judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you.
    - Law enforcement purposes, subject to subpoena or law.
    - Workers Compensation purposes.
    - Parents or guardians of a minor.

- Persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has received contractual assurances to protect the privacy of your PHI.

Is Dental Health Services ever required to get my permission before sharing my PHI?

Uses and disclosures of PHI other than those required or permitted by law will be made by Dental Health Services only with your written authorization. You may revoke any authorization given to Dental Health Services at any time by written notice of revocation to Dental Health Services, except to the extent that Dental Health Services has relied on the authorization before receiving your written revocation. Uses and disclosures beyond those required or permitted by law, or authorized by you, are prohibited.

What is Dental Health Services' "Minimum Necessary" Policy?

Dental Health Services uses reasonable efforts to limit the use and disclosure of your PHI to the minimum necessary to accomplish the purpose of the use or disclosure. This restriction includes requests for PHI from another entity, and to requests made by Dental Health Services to other entities. This restriction does not apply to the requests by:

- Your dentist for treatment purposes
- You
- Disclosures covered by an authorization you provided to another entity.

What are my rights regarding the privacy of my PHI?

You may request Dental Health Services to restrict uses and disclosures of your PHI in the performance of its payment or health care operations. However, a written request is required.

Your health is the top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your restriction, the restriction will not apply in situations involving emergency treatment by a health care provider.

Dental Health Services will comply with your reasonable requests that you wish to receive communications of your PHI by alternative means or at alternative locations. Such request must be made to Dental Health Services in writing.

You have the right to have the person you've assigned medical power of attorney, or your legal guardian, exercise your rights and make choices about your health information. We will ensure the person has this authority and can act for you before we take any action.

You have the right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act on such request within thirty (30) days of receipt of the request.

You have the right to amend your PHI. The request to amend must be made in writing and must contain the reason you wish to amend your PHI. Dental Health Services has the right to deny such requests under certain conditions provided by law. Dental Health Services will respond to your request within sixty (60) days of receipt of the request and, in certain circumstances may extend this period for up to an additional thirty (30) days.

You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to six (6) years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to disclosures made for payment or health care operations

Your request must be made in writing. Dental Health Services will provide the accounting within sixty (60) days of your request but may extend the period for up to an additional thirty (30) days. The first accounting requested during any twelve (12) month period will be made without charge. There is a $25 charge for each additional accounting requested during such twelve (12) month period. You may withdraw or modify any additional requests within thirty (30) days of the initial request in order to avoid or reduce the fee.

You have the right to receive a copy of this notice by contacting Dental Health Services at 800-637-6453 or use the TTY 711 Relay Service (for persons with a hearing or speech disability). This notice is always available at dentalhealthservices.com/privacy.

All written requests desired or required by this notice, must be delivered to Dental Health Services, 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806 by any of the following means:

- Personal delivery
- Email delivery to: membercare@dentalhealthservices.com
- First class or certified U.S. Mail
- Overnight or courier delivery, charges prepaid

What duties does Dental Health Services agree to perform?

Dental Health Services will maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices with respect to PHI.

Dental Health Services will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Dental Health Services will abide by the terms of this notice and any revised notice, during the period that it is in effect.

Dental Health Services reserves the right to change the terms of this notice or any revised Notice. Any new terms shall be effective for all PHI that it maintains including PHI created or received by Dental Health Services prior to the effective date of the new terms. Each time Dental Health Services revises this notice, it will promptly post the notice on its website and distribute a new version within sixty (60) days of revision.

Can I request confidential communication with Dental Health Services in the form and format I wish?

Members may request, and DHS shall accommodate requests for, confidential communication in the form or format requested by the member, writing or electronic communication, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until the member submits a revocation of the request or a new confidential communication request is submitted. This request will apply to all communications that disclose medical information or provider name and address related to services they receive. A confidential communications request shall be implemented by DHS within 7 calendar days of receipt of an electronic or telephonic transmission or within 14 calendar days of receipt by first-class mail. DHS shall acknowledge receipt of the confidential communications request and advise the member of the status of implementation of the request if a member contacts DHS.

Confidential communication requests can be made by contacting Dental Health Services at 800-637-6453 or membercare@dentalhealthservices.com. A member may also submit a confidential communication request by first-class mail by sending it to Dental Health Services at 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806.

Receiving confidential communication about sensitive services.

Dental Health Services is required to protect the confidentiality of a member's medical information and to not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care. "Protected individual" means any adult covered by the member's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Confidential communications request" means a request by a member that DHS' communications containing medical information be communicated to them at a specific mail or email address or specific telephone number, as designated by the member. "Sensitive services" means all health care services related to, among others, mental or behavioral health, sexual and reproductive health, sexually transmitted infe ctions, substance use disorder, gender affirming care, and intimate partner violence, obtained by a patient at or above the minimum age specified for consenting to the se rvice specified in the section.

Dental Health Services will direct certain communications regarding a member's receipt of sensitive services directly to that member receiving care. As discussed above, a protected individual may request confidential communication in a form and format that they wish, if it is readily producible in the requested form and format, and at alternative locations. If a protected individual has designated an alternative mailing address, email address, or telephone number, DHS will send or make all communications related to the protected individual's receipt of sensitive services to their alternative mailing address, email address, or telephone number. If the protected individual has not designated an alternative mailing address, email address, or telephone number, DHS shall send or make all communications related to the protected individual's receipt of sensitive services in the name of the protected individual at the address or telephone number on file.

What if I am dissatisfied with Dental Health Services' compliance with HIPAA (Health Insurance Portability and Accountability Act) privacy regulations?

You have the right to express your dissatisfaction or objection to Dental Health Services and to the Secretary of HHS if you believe your privacy rights have been violated.

Your written dissatisfaction must describe the acts or omissions you believe to be in violation of the provisions of this notice or applicable laws. Your written objection to HHS or Dental Health Services must be filed within one hundred (180) days of when you knew or should have known of the act or omission. You will not be penalized or retaliated against for communicating your dissatisfaction.

You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington DC, 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You may express dissatisfaction about Dental Health Services' privacy policy in writing to Dental Health Services, 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806, Attn: Member Satisfaction Assurance Specialist. We are eager to assist you.

Who should I contact if I have any questions regarding my privacy rights with Dental Health Services?

You may obtain further information regarding your PHI privacy rights by contacting your Member Services Specialist at 800-637-6453 during regular office hours (use the TTY 711 Relay Service if you have a hearing or speech disability), or by email at membercare@dentalhealthservices.com or anytime through dentalhealthservices.com. We are eager to assist you.

Glossary

Adverse Determination: A denial, reduction, or termination of the benefit for services received after aclaim is filed or for pre-authorized services which were denied. To appeal an Adverse Determination, see the Grievance Process section of this document.

Amalgam Filling/Restoration: A restoration or filling composed of metallic alloy formed mostly of silver, tin, and copper, mixed with mercury, into a softmalleable material that sets hard after placement inside a tooth cavity.

Appeal: A request for reconsideration of an AdverseDetermination rendered by Dental Health Services. An Appeal is processed as a Grievance.

Benefits/Coverage: The specific covered servicesthat plan Members and their Dependents are entitled to with their dental plan.

Child(ren): Eligible children are children of the Subscriber, Subscriber's spouse, or Subscriber's domestic partner. Eligible children include a biological Child; a stepchild; an adopted Child; a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner assumesa legal obligation for total or partial support in anticipation of adoption; and a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner is the legal guardian

Composite Filling/Restoration: A restorationor filling composed of plastic resin material thatresembles the natural tooth.

Comprehensive Exam: A thorough evaluation andrecording of the extraoral and intraoral hard and softtissues. Typically includes the evaluation of dental caries (cavities), missing or unerupted teeth, restorations, and occlusal relationships.

Copayments: The fees paid by the Subscriber or Member, directly to the Participating Dentist or Specialist at the time of service. The fees charged by a Participating Dentist or Specialist according to yourplan's Schedule of Covered Services andCopayments.

Dependent: An individual for whom coverage isobtained by a parent, relative, or other person.
Eligible dependents may include a legal spouse, domestic partner, or Children of the Subscriber orthe Subscriber's spouse/domestic partner.

Designated Participating Primary Dentist: The Participating Primary Dentist you have designated toprovide your dental care.

Domestic Partnership: An interpersonal relationship between two individuals who live together and share a common domestic life but arenot married to each other or to anyone else.

Emergency Dental Condition: is determined by aMember's reasonable belief that

sudden onset of symptoms in the absence of immediate medical attention could result in permanently placing their health in jeopardy, causing other serious dental or health consequences, or causing serious impairmentof dental function.

Endodontics: The branch of dentistry concerned with the treatment of disease or inflammation of thedental pulp or nerve of the tooth.

Exclusion: Treatment or coverage not included as abenefit under this plan.

Grievance: A written or oral expression of your dissatisfaction regarding Dental Health Services and/or a Participating Dentist or Participating Specialist, including your concerns about quality ofservice and care or an Appeal of an Adverse Determination of a pre-authorization or claim.

Limitation: A provision that restricts coverageunder this plan.

Medically Necessary: Dental services and supplies provided by a Participating Dentist appropriate to theevaluation and treatment of disease, condition, illnessor injury and consistent with the applicable standard of care. This does not include any service that is cosmetic in nature.

Member/Enrollee: A person who is entitled to receive dental care services under this agreement. Theterm includes both Subscribers and those family members for whom a Subscriber has paid a premium.

Optional Treatment: Treatment considered optional or unnecessary for the Member's dental health by the treating dentist. If a Member chooses anOptional Treatment, the Member is responsible for fee-for-service rates for the Optional Treatment. Thisdoes not apply to standard, covered, restorative procedures which offer a choice of material.

Out-of-Network Dentist: A dentist for whom Dental Health Services has pre-authorized to provideBenefits to Members under this Plan.

Out-of-Network Primary Dentist – A dentist for whom Dental Health Services has pre-authorized toprovide general dental services to Members coveredunder this plan.

Out-of-Network Specialist: A dentist for whom Dental Health Services has pre-authorized to provideSpecialty Services to Members cover under this plan.

Out-of-Pocket Maximum (OOPM): The maximum amount of money that a Pediatric Age Member must pay for benefits during a plan year. OOPM applies only to the Essential Health Benefitsfor pediatric aged Members. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes premium, prescriptions, or dental careyour dental plan doesn't cover.

After the Pediatric Age Member meets their OOPM,they will have no further Essential Health Benefits Copayments for the remainder of the plan year.

For families with more than one Pediatric Age Member, Essential Health Benefit Copayments madeby each individual Child for Essential Health Benefits contribute to the family Out-of-Pocket Maximum. For families with more than one Pediatric Age Member, Copayments made by each individual child for out-of-network covered services do not accumulate to the family Out-of-Pocket Maximum.

Once the Essential Health Benefits Copayments paidby all Pediatric Age Members meets the family Out- of-Pocket Maximum, no further Essential Health Benefits Copayments will be required by any of the Pediatric Age Members for the remainder of the planyear.

Palliative Care: An action that relieves pain, swelling, or bleeding. This does not include routineor postponable treatment.

Participating Dentist: A licensed dental professionalwho has entered into a written agreement with DentalHealth Services to provide dental care services to Subscribers and their Dependents covered under the plan. The agreement includes provisions in which the dentist agrees that the Subscriber shall be held liable only for their Copayment.

Participating Orthodontist: A Licensed Dentistwho specializes in orthodontics and has signed anagreement with Dental Health Services to provideBenefits to Members under this Plan.

Participating Primary Dentist: A Licensed Dentistwho has signed an agreement with Dental Health Services to provide general dental services to Members covered under this Plan.

Participating Specialist: A Licensed Dentist who provides Specialty Services to Members under this Plan, upon referral by a Participating Primary Dentist.

Pediatric Age Members: Members up to age 19.

Pediatric Dental Benefits: One of the ten Essential Health Benefits required under the Affordable Care Act (ACA). Pediatric Dental Benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

Plan Year: The Plan Year for Qualified Dental Planscorresponds to the calendar year. Your coverage endsDecember 31even if your coverage started after January 1Any changes to your Qualified Dental Plan's Benefits or rates are made at the beginning of the calendar year.

Qualified Dental Plan: A dental benefit plan that iscertified by a health benefit exchange which providesEssential Health Benefits, follows established limits on cost-sharing (like deductibles, Copayments and Out-of-Pocket Maximum amounts) and meets other requirements.

Service Area – The geographical area where Dental Health Services provides oral health care services.

Special Enrollment Period: A time outside the yearly Open Enrollment period when consumers can sign up for dental benefits coverage. Consumers qualify for a Special Enrollment Period if they've experienced certain life events, including losing healthcoverage, moving into or out of a covered Service Area, getting married, having a baby, or adopting a Child.

Specialty Services: Dental services provided by a Dental Health Services Participating Specialist (endodontist, oral surgeon, orthodontist, pedodontist/pediatric dentist, or periodontist). All referrals for covered Specialty Services must be pre-authorized by Dental Health Services.

Subscriber: A person who is responsible for the account, whose name is on the application, resides inDental Health Services' Service Area and meets planeligibility requirements.

Urgent Care: Prompt care - within 72 hours - for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but notso severe as to require emergency room care.

Urgent Grievance – A grievance that shall includeexpedited review when involving an imminent and serious threat to the health of the enrollee includingbut not limited to severe pain, potential loss of life, limb or major bodily function, or the potential improper cancellation, rescission, or nonrenewal ofan enrollment or subscription.

Usual, Customary & Reasonable: The baseamount that is treated as the standard or mostcommon charge for a particular dental service.

IMPORTANT: If English is your secondary language, you may obtain this information written in your language. For free help, call a Member Services Specialist at 866-756-4259 or dial 711 to connect to a TRS operator (for persons with a hearing or speech disability).

IMPORTANTE: Si Inglés es su segundo idioma, usted podría obtener esta información en su propio idioma. Para ayuda gratuita, llame al 866-756-4259. Dental Health Services, Inc. tiene una linea gratuita TTY 711 para personas con necesidades de audición y habla.

Dental Health Services

3780 Kilroy Airport Way, Suite 750
Long Beach, California 90806

855-495-0905
711 (TDD/TTY)

dentalhealthservices.com/CA

An Employee-Owned Company