



California Children's Dental HMO

ADA Code	Code Description	EHB Copay
Diagnostic (D0100-D999)		
D0120	Periodic oral examination - established patient	\$0
D0140	Limited oral evaluation - problem focused	\$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D0150	Comprehensive oral evaluation - new or established patient	\$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit)	\$0
D0210	Intraoral - complete series (including bitewings	\$0
D0220	Intraoral - periapical first film	\$0
D0230	Intraoral - periapical each additional film	\$0
D0240	Intraoral - occlusal film	\$0
D0250	Extraoral - first film	\$0
D0260	Extraoral - each additional film	\$0
D0270	Bitewing - single film	\$0
D0272	Bitewings - two films	\$0
D0273	Bitewings - three films	\$0
D0274	Bitewings - four films	\$0
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	Panoramic film	\$0
D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
Preventive (D1000-D1999)		
	Code Description	EHB Copay
D1110	Prophylaxis – adult	\$0
D1120	Prophylaxis – child	\$0
D1203	Topical application of fluoride (prophylaxis not included) - child	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant - per tooth	\$0
D1510	Space maintainer - fixed – unilateral	\$0
D1515	Space maintainer - fixed – bilateral	\$0
D1520	Space maintainer - removable - unilateral	\$0
D1525	Space maintainer - removable - bilateral	\$0
D1550	Recementation of space maintainer	\$0
Restorative (D2000-D2999)		
	Code Description	EHB Copay
D2140	Amalgam - one surface, primary or permanent	\$25
D2150	Amalgam - two surfaces, primary or permanent	\$40
D2160	Amalgam - three surfaces, primary or permanent	\$40
D2161	Amalgam - four or more surfaces, primary or permanent	\$40
D2330	Resin-based composite - one surface, anterior	\$40
D2331	Resin-based composite - two surfaces, anterior	\$40
D2332	Resin-based composite - three surfaces, anterior	\$40



D2390	Resin-based composite crown, anterior	\$40
D2391	Resin-based composite – one surface, posterior	\$40
D2392	Resin-based composite – two surfaces, posterior	\$40
D2393	Resin-based composite – three surfaces, posterior	\$40
D2394	Resin-based composite – four or more surfaces, posterior	\$40
D2542	Onlay – metallic - two surfaces	\$160
D2543	Onlay - metallic – three surfaces	\$160
D2544	Onlay – metallic – four or more surfaces	\$160
D2710	Crown – resin-based composite (indirect)	\$300
D2720	Crown – resin with high noble metal	\$300
D2721	Crown – resin with predominantly base metal	\$300
D2722	Crown – resin with noble metal	\$300
D2740	Crown – porcelain/ceramic substrate	\$350
D2750	Crown - porcelain fused to high noble metal	\$300
D2751	Crown - porcelain fused to predominantly base metal	\$300
D2752	Crown - porcelain fused to noble metal	\$300
D2780	Crown - 3/4 cast high noble metal	\$365
D2781	Crown - 3/4 cast predominantly base metal	\$365
D2782	Crown - 3/4 cast noble metal	\$365
D2783	Crown – ¾ porcelain/ceramic	\$365
D2790	Crown - full cast high noble metal	\$365
D2791	Crown - full cast predominantly base metal	\$365
D2792	Crown - full cast noble metal	\$365
D2910	Recement inlay, onlay, or partial coverage restoration	\$0
D2915	Recement cast or prefabricated post and core	\$0
D2920	Recement crown	\$0
D2930	Prefabricated stainless steel crown - primary tooth	\$150
D2931	Prefabricated stainless steel crown - permanent tooth	\$150
D2940	Sedative filling	\$50
D2950	Core buildup, involving and including any pins	\$100
D2951	Pin retention - per tooth, in addition to restoration	\$0
D2952	Post and core in addition to crown, indirectly fabricated	\$100
D2954	Prefabricated post and core in addition to crown	\$100
D2980	Crown repair necessitated by restorative material failure	\$40
Endodontics (D3000-D3999)	Code Description	EHB Copay
D3110	Pulp cap - direct (excluding final restoration)	\$50
D3120	Pulp cap – indirect (excluding final restoration)	\$50
D3220	Therapeutic pulpotomy (excluding final restoration)	\$50
D3310	Anterior Root Canal Therapy(excluding final restoration)	\$300
D3320	Bicuspid Root Canal Therapy (excluding final restoration)	\$365
D3330	Molar (excluding final restoration)	\$300
D3346	Retreatment of previous root canal therapy – anterior	\$390
D3347	Retreatment of previous root canal therapy – bicuspid	\$390
D3348	Retreatment of previous root canal therapy - molar	\$390
D3351	Apexification/recalcificaion – initial visit (apical closure/calcfific repair of perforations, root resorption, etc.)	\$104
D3352	Apexification/recalcification – interim medication replacement	\$104
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcfific repair perforations, root resorption, etc.)	\$104
D3410	Apicoectomy – anterior	\$201
D3421	Apicoectomy – bicuspid (first root)	\$215

D3425	Apicoectomy – molar (first root)	\$228
D3426	Apicoectomy (each additional root)	\$130
D3450	Root amputation – per root	\$111
Periodontics (D4000-D4999) {TMI: Surgery 4000-4299}	Code Description	EHB Copay
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$150
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$507
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$403
D4341	Periodontal scaling and root planing	\$75
D4342	Periodontal scaling and root planing	\$0
Removable Prosthodontics (D5000-D5899)	Code Description	EHB Copay
D5110	Complete denture – maxillary –	\$365
D5120	Complete denture – mandibular	\$365
D5130	Immediate denture – maxillary	\$365
D5140	Immediate denture – mandibular	\$365
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$365
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$365
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$365
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$365
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$365
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	\$365
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	\$365
D5410	Adjust complete denture – maxillary	\$50
D5411	Adjust complete denture – mandibular	\$50
D5421	Adjust partial denture – maxillary	\$50
D5422	Adjust partial denture – mandibular	\$50
D5510	Repair broken complete denture base	\$125
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$125
D5610	Repair resin denture base	\$125
D5620	Repair cast framework	\$125
D5630	Repair or replace broken clasp	\$125
D5640	Replace broken teeth - per tooth	\$125
D5650	Add tooth to existing partial denture	\$125
D5660	Add clasp to existing partial denture	\$125
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$234
D5671	Replace all teeth an acrylic on cast metal framework (mandibular)	\$234
D5730	Reline complete maxillary denture (chairside)	\$125
D5731	Reline complete mandibular denture (chairside)	\$125
D5740	Reline maxillary partial denture (chairside)	\$125



D5741	Reline mandibular partial denture (chairside)	\$125
D5750	Reline complete maxillary denture (laboratory)	\$150
D5751	Reline complete mandibular denture (laboratory)	\$150
D5760	Reline maxillary partial denture (laboratory)	\$150
D5761	Reline mandibular partial denture (laboratory)	\$150
D5820	Interim partial denture (maxillary)	\$250
D5821	Interim partial denture (mandibular)	\$250
D5850	Tissue conditioning, maxillary	\$75
D5851	Tissue conditioning, mandibular	\$75
Fixed Prosthodontics (D6200-D6999)	Code Description	EHB Copay
D6210	Pontic - cast high noble metal	\$365
D6211	Pontic - cast predominantly base metal	\$365
D6212	Pontic - cast noble metal	\$365
D6240	Pontic - porcelain fused to high noble metal	\$365
D6241	Pontic - porcelain fused to predominantly base metal	\$365
D6242	Pontic - porcelain fused to noble metal	\$365
D6250	Pontic - resin with high noble metal	\$365
D6251	Pontic - resin with predominantly base metal	\$365
D6252	Pontic - resin with noble metal	\$365
D6720	Crown - resin with high noble metal	\$365
D6721	Crown - resin with predominantly base metal	\$365
D6722	Crown - resin with noble metal	\$365
D6750	Crown - porcelain fused to high noble metal	\$365
D6751	Crown - porcelain fused to predominantly base metal	\$365
D6752	Crown - porcelain fused to noble metal	\$365
D6790	Crown - full cast high noble metal	\$365
D6791	Crown - full cast predominantly base metal	\$365
D6792	Crown - full cast noble metal	\$365
D6930	Re-cement or re-bond fixed partial denture	\$33
D6980	Fixed partial denture repair denture repair necessitated by restorative material failure	\$90
Oral and Maxillofacial Surgery (D7000-D7999)	Code Description	EHB Copay
D7111	Extraction, coronal remnants - deciduous tooth	\$45
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperistial flap and removal of bone and/or section of tooth	\$135
D7220	Removal of impacted tooth - soft tissue	\$135
D7230	Removal of impacted tooth - partially bony	\$135
D7240	Removal of impacted tooth - completely bony	\$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$135
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$135
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	\$40
D7286	Incisional biopsy of oral tissue - soft	\$40

D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$156
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$156
D7472	Removal of torus palatinus	\$76
D7473	Removal of torus mandibularis	\$130
D7510	Incision and drainage of abscess – intraoral soft tissue	\$130
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$40
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	\$52
Orthodontics (D8000-D8999)	Code Description	EHB Copay
Orthodontic treatment includes medically-necessary orthodontia only. Out of Pocket Maximum not to exceed \$1,000 for treatment plans up to 24 months for medically necessary orthodontia.		
D8010	Limited orthodontic treatment of the primary dentition	\$350
D8020	Limited orthodontic treatment of the transitional dentition	\$350
D8030	Limited orthodontic treatment of the adolescent dentition	\$350
D8040	Limited orthodontic treatment of the adult dentition	\$350
D8050	Interceptive orthodontic treatment of the primary dentition	\$350
D8060	Interceptive orthodontic treatment of the transitional dentition	\$350
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$350
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$350
D8090	Comprehensive orthodontic treatment of the adult dentition	\$350
D8210	Removable appliance therapy	\$0
D8220	Fixed appliance therapy	\$0
D8660	Pre-orthodontic treatment visit	\$0
D8670	Periodic orthodontic treatment visit (as part of contract)	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$0
D8690	Orthodontic treatment (alternative billing to a contract fee)	\$100
D8691	Repair of orthodontic appliance	\$0
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	\$0
Adjunctive General Services (D9000-D9999)	Code Description	EHB Copay
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia	\$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$0
D9248	Non-intravenous conscious sedation	\$0
D9310	Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$0
D9440	Office visit - after regularly scheduled hours	\$0

If services for a listed procedure are performed by the assigned PCD, the member pays the specified co-payment.



Benefits are provided if the plan determines the services to be medically necessary.

You may be charged a Copayment for missed appointments if you do not give the dental office at least 24 hours notice of cancellation.

Listed procedures, which require a dentist to provide specialized services, and are referred by the assigned PCD, must be preauthorized in writing by the Plan. The member pays the co-payment specified for such services. Procedures not listed above are not covered, however may be available at the PCD's contracted fees. "Contracted fees" means the PCD's fees on file with the Plan.

Minimum coverage plan benefits are covered at 100% by the plan after the member meets the medical plan deductible and Annual Out-of-Pocket maximum. Members are responsible for the total cost of the benefit until the deductible is met. Covered preventive and diagnostic services are covered at 100% regardless of deductible and Annual Out of Pocket.

Benefits Description

This section lists the dental benefits and services you are allowed to obtain through the Plan when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations and exclusions listed here.

Diagnostic and Preventive Benefits

Description

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (X-ray)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Limitations

Roentgenology X-rays are limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to (1) one series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months
- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
- Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic.
- Replacement of a restoration

- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary
- Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.

Oral Surgery

Description

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontics

Description

Endodontic benefits include:

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Description

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.

Crown and Fixed Bridge

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitation

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the Plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- There is an additional co-payment of \$125 per unit for treatment plans of 7 or more units.
- There is an additional co-payment of \$75 per unit for porcelain on molars.



- Actual fees will apply for any procedure involving noble, high noble, or titanium metals.
- Implants and implant-related procedures are not covered.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space Maintainer Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within thirty six (36) consecutive months, unless:
 1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
 2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an optional benefit
- Stayplates are a benefit only when used as anterior space maintainers for children
- There is an additional copayment of \$125 per unit for treatment plans of 7 or more units.
- There is an additional copayment of \$75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.
- The replacement of retainers and pontics requires the existing bridge to be 3+ years old.

Other Benefits

Description

Other dental benefits include:

- Local anesthetics



- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Orthodontic Benefits

Orthodontic treatment includes medically-necessary orthodontia only.



Excluded Benefits

The following dental benefits are excluded under the plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the "Benefits" section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation, unless specifically listed as a benefit or is given by a dentist for covered oral surgery
5. Experimental procedures.
6. Dental conditions arising out of and due to a Member's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
7. Services which were provided without cost to the Member by the State government or an agency thereof, or any municipality, county or other subdivisions.
8. Hospital charges of any kind.
9. Major surgery for fractures and dislocations.
10. Loss or theft of dentures or bridgework.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
16. The cost of precious metals used in any form of dental benefits.
17. The surgical removal of implants.
18. Services of a pedodontist/pediatric dentist for a Member, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.