Dental Health Services

Combined Evidence of Coverage and Disclosure Form

Family Dental HMO Group Dental Plan

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

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Definitions

Acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Benefits/Coverage: the specific covered services that plan members and their dependents are entitled to use with their dental plan.

Child: eligible children include a biological child; adopted child; a child for whom the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; a stepchild; or a child for whom the subscriber or the subscriber's spouse is the legal guardian.

Comprehensive exam: a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. Typically includes the evaluation of dental caries (cavities), missing or unerupted teeth, restorations, and occlusal relationships.

Copayments: the fees paid by you, the subscriber or member, directly to the participating Dental Health Services dentist at the time of service. The fees charged by a participating dentist according to your Schedule of Covered Services and Copayments.

Dependent coverage: coverage for family members of the policyholder, such as a spouse, domestic partner, and children.

Dependents: a child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction.

Domestic partners: two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring and who file a Declaration of Domestic Partnership with the Secretary of State.

Emergency dental condition: a dental condition that is characterized by the sudden onset of acute symptoms of sufficient severity that in the absence of immediate dental attention could reasonably result in permanently placing the member's health in jeopardy; causing other

serious dental or health consequences, or causing serious impairment of dental function.

Enrollee: a member who has completed an application and paid for their plan.

Exclusion: any provision in the agreement whereby coverage for a specified procedure or condition is entirely eliminated.

Limitation: any provision in this agreement that restricts coverage.

Medically necessary: health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of care.

Member: a person who is entitled to receive dental care services under this agreement. The term includes both subscribers and those family members for whom a subscriber has paid a premium.

Out-of-Pocket Maximum (OOPM): The maximum amount of money that a pediatric age enrollee must pay for benefits during a calendar year. OOPM applies only to the Essential Health Benefits for pediatric age enrollees.

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 enrollee meets their OOPM, they will have no further copayments for benefits for the remainder of the calendar year.

If more than one pediatric age enrollee is covered under the contract, the financial obligation for benefits is not more than the OOPM for multiple pediatric age enrollees. Once the amount paid by all pediatric age enrollees equals the OOPM for multiple pediatric age enrollees, no further copayments will be required by any of the pediatric age enrollees for the remainder of the calendar year.

Participating dental office: the office and facilities of the specific Dental Health Services dentist you selected to provide covered services.

Participating dentist: a licensed dental professional who has entered into a written contract/agreement with Dental Health Services to provide dental care services to members covered under the plan. The contract includes provisions in which the dentist agrees that the subscriber/member shall be held liable only for their copayments.

Pediatric Dental Benefits: One of the ten Essential Health Benefits required under the Affordable Care Act (ACA). In California, pediatric dental benefits cover dental care and services such as cleanings, x-rays, and fillings for those 18 years of age and under.

Qualified dental plan: an insurance product that is certified by a health benefit exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements. All Covered California dental plans are qualified dental plans.

Serious chronic condition: a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Special enrollment: the opportunity for people who experience a qualifying event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in a health plan, even if it is outside of Covered California's open enrollment period.

Specialty services: dental services provided by a Dental Health Services contracted or authorized dental specialist (endodontist, periodontist, pedodontist, oral surgeon, or orthodontist). All referrals for covered specialty services must be pre-authorized by Dental Health Services.

Subscriber: a person whose relationship as the primary enrollee is the basis for coverage under this agreement; account responsible.

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 not so severe as to require emergency room care.

Your Personal Dental Plan

You are important to us, and so is your healthy smile. We want to keep you smiling by helping you protect your teeth and by saving you time and money. We are proud to offer you and your family excellent dental coverage that:

- 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 receiving regular diagnostic and preventive care with low, or no copayments is the key to better health and long term savings.
- Facilitates care by making all covered services available as soon as membership becomes effective.
- Simplifies access by eliminating pre-authorization for treatment from the general dentist selected from our network of participating dentists.
- Assures availability of care with high-quality, easy-to-find dental offices throughout California. Our network is continually expanding; please contact our office at 855-495-0905 or visit www.dentalhealthservices.com/CA for the latest listing of our participating dentists.
- Allows you to take an active role in your dental health and treatment by fully disclosing coverage and exact copayments prior to treatment.

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

- ToothTips℠ oral health information sheets.
- Member Service Specialists to assist you by telephone, fax, or e-mail.
- Web access to valuable plan and oral health information at www.dentalhealthservices.com/CA.

Your Evidence of Coverage and Disclosure Form ("EOC") discloses the terms and conditions of coverage. You have a right to view this EOC prior to enrollment. Your EOC should be read completely. Dental Health Services encourages individuals with special needs to carefully review this EOC. It is important to Dental Health Services that you select dental benefits that will provide the care that is required due to your condition. If you have any questions or would like to obtain copies of your plan contract, please contact Dental Health Services at 855-495-0905 to speak to your Member Service Specialist. You may also write to Member Services, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807 or via email at membercare@dentalhealthservices.com.

About Dental Health Services

Dental Health Services is an employee-owned company founded in 1974 by a pioneering dentist whose vision was to provide patient-focused, innovative, quality dental coverage that emphasizes overall oral health and wellness. These core values continue to guide and set Dental Health Services apart in the dental health industry.

An alternative to traditional insurance (indemnity), Dental Health Services has been offering dental plans to groups and individuals throughout California for over 40 years. Dental Health Services continues to foster its mission of bringing quality, affordable dental care to those who need it. We are dedicated to ensuring your satisfaction and to keeping your plan as simple and clear as possible.

As employee-owners, we have a vested interest in the well-being of our plan members. Part of our service focus includes toll-free access to your knowledgeable Member Service Specialist, an automated member

assistance and eligibility system, and access to our website at www.dentalhealthservices.com/CA to help answer questions about your plan and its benefits.

Family Dental Benefit Matrix

This matrix is intended to be used to help you compare coverage benefits and is a summary only. Please refer to this Evidence of Coverage and your Schedule of Copayments and Covered Benefits for more information about services covered under your plan.

Deductibles	Maximums
None	Individual - $350 Family - $700

Professional Services	
Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments. Categories of services include:	
Diagnostic Services - $0 Preventive Services - $0 Restorative - $10 - $300	Periodontic Services - $15 - $300 Prosthodontic Services - $5 - $300 Orthodontic Services - $350

Outpatient Services	Hospitalization Service
No additional charge	Not covered

Emergency Dental Coverage
Please refer to the Emergency Care section of this Evidence of Coverage

Ambulance Service	Prescription Drug Coverage
Not covered	Not covered

Durable Medical Equipment	Mental Health Services
Not covered	Not covered

Chemical Dependency	Home Health Services
Not covered	Not covered

Your Participating Dentist

Service begins with the selection of local, independently-owned, Quality Assured dental offices. Professional skill, commitment to prevention and wellness, convenience

of location, and flexibility in appointment scheduling are some of the most important criteria involved in approving a participating dentist.

The ongoing member care of each dental office is monitored regularly through our rigorous Quality Assurance[sm] standards.

Your First Dental Appointment

Your initial appointment is an opportunity for you to meet the participating dentist you selected when you enrolled in your Dental Health Services plan. Your dentist will complete an oral examination and formulate a treatment plan for you based on his or her assessment of your oral health.

Your initial exam may require a copayment, and you may need additional diagnostic services (e.g., periodontal charting and x-rays). You may also be charged copayments for additional services as necessary. There is a copayment charged for each office visit regardless of the procedures performed.

After your initial visit, you may schedule an appointment for future care, such as cleanings or to complete your treatment plan. Reference your treatment 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.

Your Member Service Specialist

Please feel free to call, fax, or send an e-mail to membercare@dentalhealthservices.com. You may also write us anytime with questions or comments. We are ready to help you. Each of our Member Service Specialists is trained in dental terminology or has experience working in a dental office. They can answer your plan and dental questions. Your Member Service Specialist can be reached through any of the following ways:

Phone: 855-495-0905
Fax: 562-424-6088
Email: membercare@dentalhealthservices.com
Web: www.dentalhealthservices.com/CA
Mail: Dental Health Services
3833 Atlantic Avenue
Long Beach, CA 90807

Eligibility

As the subscriber, you may enroll yourself, your spouse or your domestic partner (unless legally separated), and/or dependent children who are under 26 years of age. Enrollees are not required to have children to enroll in this Family Dental HMO.

Children 26 years of age and over are eligible if the child is and continues to be both (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance.

A family must enroll all children in a family in the pediatric dental benefit for any one child in the family to be eligible for benefits under the plan.

For disabled dependents, Dental Health Services will provide notice to the subscriber at least 90 days prior to the dependent's attainment of the limiting age. Coverage for their disabled dependent will terminate upon the dependent's attainment of 26 years of age, unless proof of incapacity or dependency is provided to Dental Health Services within 60 days from the date the subscriber received the notice.

Dental Health Services may require ongoing proof of the dependent's incapacity or dependency, but not more frequently than annually after the two-year period following the child's attainment of 26 years of age.

Disabled dependents enrolling for new coverage may initially be required to show proof of incapacity and dependency, and then not more than annually to ensure the dependent continues to meet the conditions above. Proof must be provided within 60 days of such request.

Failure to do so may result in termination of your dependent's eligibility. Disabled dependent must have been enrolled as a dependent under the subscriber or spouse/domestic partner under a previous health plan at the time the dependent reached the limiting age.

Enrollment

Enrollment rates are based on a term of one year and continue until terminated according to procedures contained in this brochure.

Dependents must be added at the time of initial enrollment or during open enrollment. If you experience a qualifying event, you may be eligible for a sixty (60) day special enrollment period. You must report this event within 60 days of the event to Covered California through their web portal at www.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 the web portal. Covered California may grant you a special enrollment period due to one of the following 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 or becomes a dependent through marriage, birth, adoption or placement for adoption;
3. An individual who previously was not a citizen of 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 or the Covered 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 contract between the individual and 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 sharing reductions;
7. A permanent move has given the individual access to a new qualified dental plan;
8. An individual is a member of a federally recognized American Indian Indian or Alaska Native Tribe. Individuals may enroll in or change qualified dental plans one time each month;
9. An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value; and
10. An individual demonstrates to Covered California that in accordance with guidelines provided by HHS the individual meets other exceptional circumstances as Covered California may provide.

For complete detailed enrollment provisions set forth by Covered California in accordance with the guidelines provided by HHS, please go to the Covered California web portal at www.coveredca.com.

Coverage Effective Dates

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

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

Loss of Medi-Cal or Job-Based Coverage:

If you experience of 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 of the 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 date the enrollment request was submitted.

Newborn and Adoptive Children:

A newborn, or a child placed for adoption is eligible for coverage from the moment of birth or placement. You must apply through Covered California to enroll your new dependent. 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.

Dependent Additions Due to Marriage:

The effective date for dependents acquired through marriage will be effective the first day of the next 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 a case by case basis.

Receiving Dental Care

Upon enrollment, a participating dentist should be selected to provide dental care. You can find a list of Dental Health Services' Participating Dentists online at

www.dentalhealthservices.com/CA or through www.coveredca.com. For a printed directory, call 855-495-0905.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears online with the dental office address or in Dental Health Services' Directory of Participating Dentists, and request an appointment. Routine appointments will be scheduled within a reasonable time; in non-emergency cases, reasonable time shall not be more than three weeks. You are only eligible for services at your participating dentist's office, except in an emergency situation or for pre-authorized specialty care provided by a participating specialist.

All referrals for specialist services must be requested by your participating dentist and pre-authorized by Dental Health Services. Please see the Authorization, Modification, or Denial of Services section of this document for additional information. If treatment authorization is denied, you have the right to appeal the denied determination.

Each dental office is independently-owned and establishes its own policies, procedures, and hours. If you need to cancel your appointment, please call your dental office at least 24 hours' prior to your scheduled appointment time. A penalty may be assessed if your dental appointment is cancelled with less than 24 hours notice. For your participating dentist's policies and procedures, please contact the dentist office directly.

Language and Communication Assistance

Good communication with Dental Health Services and with your dentist is important. If English is not your first language, Dental Health Services provides interpretation services and translation of certain written materials.

To ask for language services, or if you have a preferred language, please notify us of your personal language needs by calling Dental Health Services at 855-495-0905.

If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance services by calling Dental Health Services at 888-645-1257 (TDD/TTY).

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 are only provided by participating dentists who are contracted with Dental 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 dental plan.

Participating dentists are responsible for providing dental advice or treatment independently, and without interference from Dental Health Services or any affiliated agents. If a satisfactory relationship between Member and Participating Dentist cannot be established, Dental Health Services, the Member, or the Participating Dentist, reserves the right to request a termination of that relationship.

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 after receipt of the request. Dental Health Services will always put forth its best effort to place the member with another dentist.

Quality Assurance℠

We're confident about the care you'll receive because our dentists meet and exceed the highest standards of care demanded by our Quality Assurance℠ program. Before we contract with our dentists, we visit their offices to make sure your needs will be met. Dental Health Services' Professional Service Specialists regularly meet

and work with our dentists to maintain excellence in dental care.

Dentist Access Standards – Primary Care

Dental Health Services strives to ensure you have access to a Quality Assured primary care 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 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 company access standards, out-of-area access may be authorized. In the event of an emergency, please see the Emergency Care: Out-of-Area Benefits section for guidelines.

Dentist Access Standards – Specialists

As a Dental Health Services member, you have access to over 2,000 Quality Assured specialists, including orthodontists, oral surgeons, endodontists, pediatric dentists, and periodontists. You may receive care from any participating specialist with a referral from your primary care dentist. For more information about Dental Health Services' referral process, please refer to the Receiving Dental Care section of this brochure.

If access to a specialist is not within reasonable proximity of your business or residence, Dental Health Services will work with your Primary Care Dentist to authorize out-of-area access. In addition, the company will seek recruitment of dentists who meet our Quality Assurance Standards and are close to you. In the event of an emergency, please see the Emergency Care: Out-of-Area Benefits section for guidelines.

Changing Dental Offices

If you wish to change dentists, you must notify Dental Health Services. This may be done by phone, in writing, by email, by fax, or online. Requests can be made by calling your Member Service Specialist at 855-495-0905 or by sending via fax to 562-424-6088. Online changes can be done through www.dentalhealthservices.com/CA.

Requests received by the 10th of the current month become effective the first day of the following month. Changes made after the 10th become effective the first day of the second month following receipt.

Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you to be seen by another participating dentist. You should bring your x-rays to this consultation. If no x-rays are necessary, you will pay only your office visit and second opinion copayment ($20).

Arrangements will be made within five days for routine second opinions, within 72 hours for serious conditions, and immediately for emergencies.

After you receive your second opinion, you may return to your initial participating dental office for treatment. If, however, you wish to select a new dentist you must contact Dental Health Services directly, either by phone, online or in writing, before proceeding with your treatment plan.

Treatment Authorization

Dental Health Services works closely with our providers to deliver quality dental care and to protect our members. Authorization and utilization management specialists verify eligibility, authorize services, and facilitate the delivery of dental care to members. Services are authorized based on the benefits, limitations, and exclusions listed in each plan's Combined Evidence of Coverage and Disclosure Form.

Specialty services, if covered by your plan, require pre-authorization by Dental Health Services. The pre-authorization should be requested by your participating dentist. Your treatment is approved and rendered according to your plan benefits. If treatment authorization is denied, you have the right to appeal the denied determination.

Authorization, Modification, or Denial 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-network or are approved out-of-network providers.
- Status of any applicable maximums.
- Requested submission of necessary clinical documentation.
- Submission of proper procedure coding.
- Accurate submission of referral as explained in the Provider Manual.

If Dental Health Services is unable to complete a review within the required time frame, it will immediately, upon the expiration of the require time frame or as soon as the plan become aware that it will not meet the time frame, whichever occurs first, notify the provider and enrollee in writing:

- That it is unable to make the decision within the required time frame because the plan does not have all reasonably necessary information requested or requires an expert consultation or additional examination;
- What specific information has been requested but not received, or any additional examination or test

required, or specifying the expert reviewer to be consulted; and

- Of the anticipated date when a decision will be made (notice to enrollee only).

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

Prior authorization is not required for emergency or urgent services. Please see the following sections in this document for specifics: Emergency Care: In-Area, Emergency Care: Out-of-Area, Urgent Care.

Your Financial Responsibility

You are liable to pay your participating dentist for copayments and incidental broken appointment penalties or interest charges. Please be aware that you are also liable for any other amounts owed for non-covered services. All dental treatment copayments are to be paid at the time of service directly to your participating dental office.

As stated under the Emergency Care: Out-of-Area section of this booklet, for services rendered by a non-contracted dentist, Dental Health Services will reimburse up to $100 per occurrence for the cost of emergency care beyond your copayment. You are liable for any other costs.

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

Covered California - Coordination of Benefits

Covered California's standard benefit design requires that stand alone dental plans offering the pediatric dental benefit, such as this Dental Health Services plan, whether as a separate benefit or combined with a family dental benefit, cover benefits as a secondary payer.

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 plan is coordinating benefits with your Dental Health Services plan, Dental Health Services will pay the lesser of either the amount that it would have paid in the 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 Health Services. If you are wishing to coordinate coverage with your primary dental benefits carrier, please call Member Services at 855-495-0905.

Your participating dentist submits Utilization and Encounter Forms for services provided, on a monthly basis. 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 Specialist to Dental Health Services for processing and payment.

Out-of-Pocket Maximum

Out-of-pocket maximum is the total amount of co-payments you'll need to pay on your own before your plan benefits are paid in full. Once you've met the out-of-pocket maximum for a plan year, you will not be required to pay further copayments for covered dental services under your Dental Health Services plan. Please see the Definitions section of this document for a full description of Out-of-Pocket Maximum.

Dental Health Services monitors your out-of-pocket payments over the course of your plan year. When those payments reach the Out-of-Pocket Maximum for your plan, we will send a letter to both you and your selected Quality Assured dentist to ensure that you are not responsible for copayments for future services.

You are encouraged to track your Out-of-Pocket expenses by retaining receipts for all of the services you received that are covered under your Dental Health Services plan through the plan year. Never hesitate to ask your participating Quality Assured dentist for an itemized receipt of services provided during your visit.

Liability of Subscriber for Payment

You will be liable for the cost of non-covered services performed by a participating dentist and for any services performed by a non-participating dentist that Dental Health Services does not pre-approve or pay. 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 dental provider may charge you his or her usual and customary 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 Member Services at 855-495-0905. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

Optional Treatment

If you choose a more expensive elective treatment in lieu 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 any questions about optional treatment or services you are asked to pay additional for, please contact your Member Service Specialist before you begin services or sign any agreements.

Emergency Care: In-Area

Palliative (pain relief) care for emergency dental conditions (see Emergency Dental Condition under Definitions) such as acute pain, bleeding, or swelling is a benefit according to your Schedule of Covered Services and Copayments. Prior authorization is not required for emergency care services.

If you have a dental emergency and need to seek immediate care, first call your participating Dental Health Services dentist. Participating dental offices maintain 24-hour emergency communication accessibility and are expected to see you within 24 hours of contacting the dental office or within such lesser time as may be medically indicated. If your dentist is not available, call your Member Service Specialist. If both the dental office and Dental Health Services cannot be reached, you are covered for emergency care at another participating dentist, or from any dentist. You will be reimbursed for the cost of emergency palliative treatment less any copayments that apply. Contact your selected provider for follow-up care as soon as possible.

If you have a life-threatening medical emergency, you should get care immediately by calling 911 or going to the nearest hospital emergency room.

Emergency Care: Out-of-Area

Out-of-area emergency care is emergency palliative dental treatment required while an enrollee is anywhere outside of Dental Health Services' service area and provided by an out-of-network provider. Prior authorization is not required for out-of-area emergency care, 24 hours a day.

Your benefit includes up to $100.00 reimbursement per enrollee per incident, after copayments are deducted. You must submit an itemized receipt from the dental office that provided the emergency service with a brief explanation, and your subscriber ID number, to Dental Health Services within 180 days of the date dental treatment was rendered. After 180 days, Dental Health Services reserves the right to refuse payment. Contact your selected provider for follow-up care as soon as possible.

Urgent Care

Urgent care includes conditions that do not necessarily 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 of within 72 hours. If an urgent dental situation occurs, please contact Your Participating Dentist or Member Services at 855-495-0905 for an urgent referral. Prior authorization is not required for urgent services.

Continuity of Care

If you are currently in the middle of treatment and your current participating dentist is terminated or you are joining Dental Health Services as a new enrollee, you may have the right to keep your current dentist for a designated period of time. Please contact your Member Service Specialist at 855-495-0905 or www.dentalhealthservices.com/CA for assistance and to request a copy of Dental Health Services' Continuity of Care Policy.

New Members: You may request continuation of covered services for certain qualifying conditions from your non-participating provider. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of certain qualifying conditions if the covered services were being provided by a non-participating provider to a newly covered enrollee at the time his or her 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 of covered services for certain qualifying conditions from your participating provider in the event that the provider's contract is terminated. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of qualifying conditions if the services are provided by a dental office that

is no longer contracted with Dental Health Services. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered.

Qualifying Conditions: The enrollee 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 prompt medical attention and has a limited duration;
- Completion of covered services for an enrollee who is a newborn child between birth and age 36 months, not to exceed 12 months from the contract termination date for current enrollees or 12 months from the effective date of coverage for a newly covered enrollee;
- Performance of a surgical or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the provider's contract termination for current enrollees or 180 days from the effective date of coverage for newly covered enrollees.

All services are subject to Dental Health Services' consent and approval, and agreement by the terminated provider, consistent with good professional practice. You must make a specific request to continue under the care of your current dental provider. Dental Health Services is not required to continue your care with the provider if you are not eligible under our policy or if we cannot reach agreement with the provider 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-HMO-2219, at a TDD number for the hearing impaired at 877-688-9891, or online at www.hmohelp.ca.gov.

Termination of Benefits

Covered California determines eligibility and continued eligibility for coverage. Notices or questions regarding cancelling or termination of coverage should be directed to Covered California at 800-300-1506.

Upon cancelling any member's dental benefits plan, Dental Health Services will notify the subscriber in writing of the reason(s) for cancelling the coverage, by mail, at least 30 days prior to cancelling their coverage.

Dental Health Services may terminate coverage of an individual member may be terminated for the following reasons:

- If information contained in the application or otherwise provided to Dental Health Services by the subscriber or member or anyone acting on their behalf, was intentionally or materially incomplete or inaccurate.
- If the subscriber no longer lives or works in the Dental Health Services service area.
- If the subscriber or member is fraudulent or deceptive in obtaining, or attempting to attain, benefits for themselves, or for another person, under this plan.

See the Termination of Benefits for Nonpayment section of this document for specific details about termination due to unpaid premiums.

Coverage for the member and his/her dependents will terminate at of the end of the month during which the subscriber/member 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 the subscriber at least 15 days prior to cancelling the coverage or the group representative will provide adequate Notice of Termination to the subscriber. In the event coverage is terminated, the member shall become 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) or special enrollment through Covered California (see Special Enrollments).

Termination Due to Nonpayment

Benefits under this plan depend on premium payments being current. Dental Health Services will issue a Notice of Termination to a subscriber, employer, or contract holder for nonpayment. Dental Health Services will provide you a 30-day grace period, which begins after the last day of paid coverage. Although you will continue to be covered during this 30-day grace period, you will be financially responsible for the premium for the coverage provided during the 30-day grace period.

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

Any service(s) then "in progress" can be completed within the 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.

If you wish to terminate your coverage immediately, contact Member Services at 855-495-0905 as soon as possible.

Review of Termination

If you believe your membership was terminated by Dental Health Services solely because of ill health or your need for care, you may request a review of the termination from Dental Health Services' Dental Director. You may also request a review from the Department of Managed Health Care.

Renewal Provisions

The group contract may be extended or renewed from year-to-year after its initial period at the request of the group. The renewed contract will reflect any changes in terms and/or conditions required by Covered California and agreed upon by Dental Health Services and your group. This may affect your copayment and/or premium fees. You may obtain information about these charges, if any, from your Client Service Manager during your open enrollment period or by contacting your Member Service Specialist at 855-495-0905.

Special Enrollments

You may be eligible to enroll for coverage outside the Covered California open enrollment period. Connect with Covered California at www.coveredca.com for special enrollment considerations.

Termination of Coverage by Enrollee

The enrollee may cancel their plan through the Covered California web portal under the following circumstances:

1. Enrollee obtains other essential dental health benefits through another qualified dental plan during an open enrollment or special enrollment period.
2. Death of the enrollee.

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

Re-enrollment

Re-enrollment will be facilitated through the Covered California web portal according to terms and conditions thereunder. All payments in arrears must be satisfied prior to re-enrollment. Please go to www.coveredca.com for additional information regarding your re-enrollment rights.

Individual Continuation of Benefits

Continuation of Coverage COBRA Benefits

Consolidated Omnibux 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), as well as to administer all notification requirements and premium 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 COBRA for a minor child.

COBRA participants will receive the same dental benefits as current employees enrolled in a Dental Health 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 30 days of the 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 Dental Health Services within 60 days after any of the following qualifying events:

1. Employee divorces or legally separates
2. A child or other dependent no longer qualifies as a 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 qualifying event has occurred.

Election Period: The employee has 60 days to notify Dental Health Services in writing that the employee wants 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 monthly as 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 Dental Health Services

- Former employee becomes Medicaid eligible
- Employee enrolls in another dental plan
- Employee commits fraud, which means the former employee 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 CONTINUATION BENEFITS 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. This is called continuation health coverage or continuation of 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 than gross misconduct)

c. Reduction in hours

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

e. Dependent ceases to be eligible as a dependent

f. Covered employees eligibility of coverage under 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 a total of 36 months. Because Dental Health Services is a 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 18-month extension after COBRA through Cal-COBRA.

Each qualified person may independently enroll in Cal-COBRA. A parent or legal guardian may elect Cal-COBRA for a minor child.

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

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

Employer Deadlines:

1. Notification of Qualifying Event - The employer must notify Dental Health Services within 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 Health Services within 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 qualifies as 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 14 days after Dental Health Services has been notified that a qualifying event has occurred.

Election Period: The employee has 60 days to notify Dental Health Services in writing that employee wants to elect /enroll in Cal-COBRA coverage. The 60 days starts on the later of the following 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 by Dental Health Services within 45 days after Cal-COBRA is elected. The first premium will cover the time period between the employees loss of coverage due to a qualifying event up to the day of Cal-COBRA enrollment. Cal-COBRA premiums will continue monthly as long as Cal-COBRA coverage is continued.

Employee will lose Cal-COBRA coverage if:

a. Premiums payments are not made on time

b. Employee moves outside of Dental Health Services' service area

c. Group terminates group dental plan with Dental Health Services

d. Former employee becomes Medicaid eligible

e. Employee enrolls in another dental plan

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

Grievance Procedure

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.

You should, but it is not required, first discuss any grievance regarding treatment or treatment costs with your dentist. For assistance, you may contact your Member Service Specialist by calling 855-495-0905, mailing a letter to Member Services, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807, or by emailing grievance-web@dentalhealthservices.com.

You have 180 calendar days following any incident or action that is the subject of your dissatisfaction to file your grievance. Grievances are addressed immediately and responded to in writing within five days. Every effort will be made by Dental Health Services to resolve grievances within 30 business days of receiving the grievance or notification. Urgent grievances are addressed immediately and responded to in writing within 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 assume a portion or all of an enrollee's or subscriber's share of the fees and expenses of the neutral arbitrator.

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, although this 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 more than 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 that are 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Confidentiality and Privacy Notice

Dental Health Services 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 get access to this information. Please review it carefully. This notice is updated effective April 1, 2014.

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information that we may obtain or to which we have access. We do not sell our client information. Your personal information will not be

disclosed to nonaffiliated third parties, unless permitted or required by law, or authorized in writing by you. Additionally, Dental Health Services will not use your member information for marketing purposes.

Throughout this Notice, unless otherwise stated, your medical and dental health information refers to only health information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). 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.

Dental Health Services' privacy policies describe who has access to your PHI within the organization, how it will be used, when your PHI may be disclosed, safeguards to protect the privacy of your PHI and the training we provide our employees regarding maintaining and protecting your privacy.

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 payment and health care administration.

- **Payment purposes** include activities to collect premiums and to determine or maintain coverage. These include using PHI in billing and collecting premiums, and related data processing including how your dentist obtains pre-authorization for certain dental services. For example, Dental Health Services periodically conducts quality assurance inspections of your dentist's office and during such visits may review your dental records as part of this audit.

- **Health Care Administration** means basic activities essential to Dental Health Services' function as a Limited Health Care Service Contractor, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services such as referrals for specialists, and information including answering enrollee inquiries but without disclosing PHI. Dental Health Services may, for example, review your dentist's records to determine if the copayments being charged by the office comply with the contract under which you receive dental coverage.

- In addition, Dental Health Services is permitted to use and disclose your PHI, without your authorization, in a variety of other situations, each subject to limitations imposed by law. These situations include, but are not limited to, the following uses and disclosures:

    - 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; and
- 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.

Does my employer have the right to access my PHI?

If you are an enrollee under a plan sponsored by your employer, Dental Health Services will not disclose PHI to your employer except under the following conditions:

- you sign an authorization for release of your medical/dental information; or
- health care services were provided with specific prior written request and expense of the employer, and are relevant in a grievance, arbitration or lawsuit, or describe limitations entitling you to leave from work or limit work performance.

Any such disclosure is subject to Dental Health Services' "minimum necessary" disclosures policy.

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 requests by:

- your dentist for treatment purposes;
- you; or
- 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 requested 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 requests 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 a 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 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 60 days of receipt of the request and, in certain circumstances may extend this period for up to an additional 30 days.
- You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to 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 60 days of your request but may extend the period for up to an additional 30 days. The first accounting requested during any 12-month period will be made without charge. There is a $25 charge for each additional accounting requested during such 12-month period. You may withdraw or modify any additional requests within 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, and any amended Privacy Notice, upon written or telephone request made to Dental Health Services.

All written requests for the purposes described in this section, and all other written communications to Dental Health Services desired or required by this Notice, must be delivered to Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807 by any of the following means:

- personal delivery;
- email delivery to: membercare@dentalhealthservices.com;

- first class or certified U.S. Mail; or
- 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 makes a revised Notice, it shall 1) post it on its website, www.dentalhealthservices.com and 2) distribute a written copy personally by First Class U.S. Mail to each of its subscribers who are enrolled with Dental Health Services during the period that such revised Notice remains effective.

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. 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/. Grievances to Dental Health Services must be made in writing to Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807 Attn:

Privacy Officer. 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 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. 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 Dental Health Services Member Service Specialist at 855-495-0905 during regular office hours or through www.dentalhealthservices.com.

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 are interested in membership of the committee or would like to comment, send your request in writing to the Public Policy Committee Coordinator, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807-3505.

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 DMV office for a donor card.

English

IMPORTANT: Can you read this? If not, we can have someone help you read it. You may also be able to get this information written in your language. For free help, please call right away at 1-866-756-4259. Dental Health Services has a toll free TTY line 1-888-645-1257 for the hearing and speech impaired.

Spanish

IMPORTANTE: ¿Puedes leer esto? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta información escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-866-756-4259. Dental Health Services también tiene una línea TTY 1-888-645-1257 para personas con dificultades de audición o de hablar.

Dental Health Services

3833 Atlantic Avenue
Long Beach, CA 90807
855-495-0905
www.dentalhealthservices.com/CA

An Employee-Owned Company

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Dental Health Services

Schedule of Covered Services and Copayments
Family Dental HMO SHOP Plan (CA-FD)

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
	Deductible	None	
	Out of Pocket Maximum - Family	700	
	Out of Pocket Maximum - Individual	350	
D9543	Office Visit	0	0
	NC indicates the procedure is not covered		

Diagnostic

Code	Description	Child 18 and under	Adult 19+
D0120	periodic oral evaluation - established patient	0	0
D0140	limited oral evaluation - problem focused	0	0
D0150	comprehensive oral evaluation - new or established patient	0	0
D0160	detailed and extensive oral evaluation - problem focused, by report	0	0
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	0	0
D0180	comprehensive periodontal evaluation - new or established patient	0	0
D0190	screening of a patient	0	0
D0191	assessment of a patient	0	0
D0210	intraoral - complete series of radiographic images	0	0
D0220	intraoral - periapical first radiographic image	0	0
D0230	intraoral - periapical each additional radiographic image	0	0
D0240	intraoral - occlusal radiographic image	0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0	0
D0270	bitewing - single radiographic image	0	0
D0272	bitewings - two radiographic images	0	0
D0273	bitewings - three radiographic images	0	0
D0274	bitewings - four radiographic images	0	0
D0277	vertical bitewings - 7 to 8 radiographic images	0	0
D0330	panoramic radiographic image	0	0
D0415	collection of microorganisms for culture and sensitivity	0	0
D0425	caries susceptibility tests	0	0
D0460	pulp vitality tests	0	0
D0470	diagnostic casts	0	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	0	0
D0601	caries risk assessment and documentation, with a finding of low risk	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk	0	0
D0603	caries risk assessment and documentation, with a finding of high risk	0	0

Preventive

Code	Description	Child 18 and under	Adult 19+
D1110	prophylaxis - adult (limited to 1 per 6 months & additional at higher copayments)	0	0
D1120	prophylaxis - child (limited to 1 per 6 months & additional at higher copayments)	0	0
D1206	topical application of fluoride varnish	0	0
D1208	topical application of fluoride – excluding varnish	0	NC
D1310	nutritional counseling for control of dental disease	0	0
D1330	oral hygiene instructions	0	0
D1351	sealant - per tooth	0	NC
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	0	0

Space Maintainers

Code	Description	Child 18 and under	Adult 19+
D1510	space maintainer - fixed - unilateral	0	NC
D1515	space maintainer - fixed - bilateral	0	NC
D1520	space maintainer - removable - unilateral	0	NC
D1525	space maintainer - removable - bilateral	0	NC
D1550	re-cement or re-bond space maintainer	0	0
D1555	removal of fixed space maintainer	0	0

Amalgam Restorations - Primary or Permanent

Code	Description	Child 18 and under	Adult 19+
D2140	amalgam - one surface, primary or permanent	25	25
D2150	amalgam - two surfaces, primary or permanent	25	25
D2160	amalgam - three surfaces, primary or permanent	25	25
D2161	amalgam - four or more surfaces, primary or permanent	25	25

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Code	Description	Copayment Child 18 and under	Copayment Adult 19+

Resin-Based Composite Restorations

D2330	resin-based composite - one surface, anterior	25	25
D2331	resin-based composite - two surfaces, anterior	25	25
D2332	resin-based composite - three surfaces, anterior	25	25
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	25	25
D2390	resin-based composite crown, anterior	25	25
D2391	resin-based composite - one surface, posterior	40	40
D2392	resin-based composite - two surfaces, posterior	40	40
D2393	resin-based composite - three surfaces, posterior	40	40
D2394	resin-based composite - four or more surfaces, posterior	40	40

Crowns - Single Restoration Only

Base Metal is the benefit; Additional fees of $125 for noble metal/$150 for high noble metal, $100 for porcelain on molars, $50 for porcelain butt margin, and $200 for specialized crowns such as Lava, Captek, Empress, Procera, etc. apply.

D2543	onlay - metallic - three surfaces	300	300
D2544	onlay - metallic - four or more surfaces	300	300
D2710	crown - resin-based composite (indirect)	300	300
D2740	crown - porcelain/ceramic substrate	300	300
D2750	crown - porcelain fused to high noble metal	300	300
D2751	crown - porcelain fused to predominantly base metal	300	300
D2752	crown - porcelain fused to noble metal	300	300
D2780	crown - 3/4 cast high noble metal	300	300
D2781	crown - 3/4 cast predominantly base metal	300	300
D2782	crown - 3/4 cast noble metal	300	300
D2783	crown - 3/4 porcelain/ceramic	300	300
D2790	crown - full cast high noble metal	300	300
D2791	crown - full cast predominantly base metal	300	300
D2792	crown - full cast noble metal	300	300

Other Restorative Services

D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	10	10
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	10	10
D2920	re-cement or re-bond crown	10	10
D2929	prefabricated porcelain/ceramic crown – primary tooth	60	60
D2930	prefabricated stainless steel crown - primary tooth	60	60
D2931	prefabricated stainless steel crown - permanent tooth	60	60
D2932	prefabricated resin crown	60	60
D2933	prefabricated stainless steel crown with resin window	80	80
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	80	80
D2940	protective restoration	10	10
D2950	core buildup, including any pins when required	25	25
D2951	pin retention - per tooth, in addition to restoration	20	20
D2952	post and core in addition to crown, indirectly fabricated	70	70
D2954	prefabricated post and core in addition to crown	55	55
D2955	post removal	55	55
D2980	crown repair necessitated by restorative material failure	60	60
D2981	inlay repair necessitated by restorative material failure	20	20
D2982	onlay repair necessitated by restorative material failure	20	20
D2990	resin infiltration of incipient smooth surface lesions	2	2

Endodontics

D3110	pulp cap - direct (excluding final restoration)	12	12
D3120	pulp cap - indirect (excluding final restoration)	6	6
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	17	17
D3221	pulpal debridement, primary and permanent teeth	17	17
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	17	17
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	60	60
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	70	70
D3310	endodontic therapy, anterior tooth (excluding final restoration)	300	300
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	300	300
D3330	endodontic therapy, molar (excluding final restoration)	300	300

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Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D3346	retreatment of previous root canal therapy - anterior	300	300
D3347	retreatment of previous root canal therapy - bicuspid	300	300
D3348	retreatment of previous root canal therapy - molar	300	300
D3351	apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	22	22
D3352	apexification/recalcification – interim medication replacement	22	22
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	22	22
D3410	apicoectomy - anterior	75	75
D3421	apicoectomy - bicuspid (first root)	75	75
D3425	apicoectomy - molar (first root)	75	75
D3426	apicoectomy (each additional root)	75	75
D3430	retrograde filling - per root	45	45

Periodontics

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
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	150	150
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	40	40
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	300	300
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	200	200
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	300	300
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	200	200
D4341	periodontal scaling and root planing - four or more teeth per quadrant	17	17
D4342	periodontal scaling and root planing - one to three teeth per quadrant	15	15
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	17	17
D4910	periodontal maintenance (first 2 cleanings within calendar year)	17	17

Dentures

Dentures and partials include four months free adjustments. Add lab cost of any gold.

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5110	complete denture - maxillary	300	300
D5120	complete denture - mandibular	300	300
D5130	immediate denture - maxillary	300	300
D5140	immediate denture - mandibular	300	300
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	300	300
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	300	300
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	300	300
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	300	300
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	300	300
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	300	300
D5281	removable unilateral partial denture - one piece cast metal (including clasps and teeth)	300	300

Denture Adjustments & Repairs

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5410	adjust complete denture - maxillary	5	5
D5411	adjust complete denture - mandibular	5	5
D5421	adjust partial denture - maxillary	5	5
D5422	adjust partial denture - mandibular	5	5
D5510	repair broken complete denture base	30	30
D5520	replace missing or broken teeth - complete denture (each tooth)	15	15
D5610	repair resin denture base	30	30
D5620	repair cast framework	30	30
D5630	repair or replace broken clasp - per tooth	15	15
D5640	replace broken teeth - per tooth	20	20
D5650	add tooth to existing partial denture	20	20
D5660	add clasp to existing partial denture - per tooth	30	30
D5710	rebase complete maxillary denture	125	125
D5711	rebase complete mandibular denture	125	125
D5720	rebase maxillary partial denture	125	125
D5721	rebase mandibular partial denture	125	125
D5730	reline complete maxillary denture (chairside)	70	70
D5731	reline complete mandibular denture (chairside)	70	70

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Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5740	reline maxillary partial denture (chairside)	70	70
D5741	reline mandibular partial denture (chairside)	70	70
D5750	reline complete maxillary denture (laboratory)	95	95
D5751	reline complete mandibular denture (laboratory)	95	95
D5760	reline maxillary partial denture (laboratory)	95	95
D5761	reline mandibular partial denture (laboratory)	95	95
D5821	interim partial denture (mandibular)	90	90
D5821	interim partial denture (mandibular)	90	90
D5850	tissue conditioning, maxillary	30	30
D5851	tissue conditioning, mandibular	30	30
D5863	overdenture – complete maxillary	300	300
D5864	overdenture – partial maxillary	300	300
D5899	unspecified removable prosthodontic procedure, by report	10	10

Bridges

Base Metal is the benefit; Additional fees of $125 for noble metal/$150 for high noble metal, $100 for porcelain on molars, $50 for porcelain butt margin, and $200 for specialized crowns such as Lava, Captek, Empress, Procera, etc. apply.

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D6210	pontic - cast high noble metal	300	300
D6211	pontic - cast predominantly base metal	300	300
D6212	pontic - cast noble metal	300	300
D6214	pontic - titanium	300	300
D6240	pontic - porcelain fused to high noble metal	300	300
D6241	pontic - porcelain fused to predominantly base metal	300	300
D6242	pontic - porcelain fused to noble metal	300	300
D6610	retainer onlay - cast high noble metal, two surfaces	300	300
D6611	retainer onlay - cast high noble metal, three or more surfaces	300	300
D6612	retainer onlay - cast predominantly base metal, two surfaces	300	300
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	300	300
D6614	retainer onlay - cast noble metal, two surfaces	300	300
D6615	retainer onlay - cast noble metal, three or more surfaces	300	300
D6740	retainer crown - porcelain/ceramic	300	300
D6750	retainer crown - porcelain fused to high noble metal	300	300
D6751	retainer crown - porcelain fused to predominantly base metal	300	300
D6752	retainer crown - porcelain fused to noble metal	300	300
D6780	retainer crown - 3/4 cast high noble metal	300	300
D6781	retainer crown - 3/4 cast predominantly base metal	300	300
D6782	retainer crown - 3/4 cast noble metal	300	300
D6783	retainer crown - 3/4 porcelain/ceramic	300	300
D6790	retainer crown - full cast high noble metal	300	300
D6791	retainer crown - full cast predominantly base metal	300	300
D6792	retainer crown - full cast noble metal	300	300
D6794	retainer crown - titanium	300	300
D6930	re-cement or re-bond fixed partial denture	12	12
D6980	fixed partial denture repair necessitated by restorative material failure	15	15

Oral Surgery

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D7111	extraction, coronal remnants - deciduous tooth	15	15
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	65	65
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	50	50
D7220	removal of impacted tooth - soft tissue	60	60
D7230	removal of impacted tooth - partially bony	80	80
D7240	removal of impacted tooth - completely bony	160	160
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	160	160
D7250	surgical removal of residual tooth roots (cutting procedure)	50	50
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	80	80
D7286	incisional biopsy of oral tissue-soft	75	75
D7288	brush biopsy - transepithelial sample collection	30	30
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	25	25
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	25	25
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	25	25
D7410	excision of benign lesion up to 1.25 cm	30	30
D7411	excision of benign lesion greater than 1.25 cm	300	300
D7412	excision of benign lesion, complicated	300	300
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	300	300
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	300	300

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Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	300	300
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	300	300
D7471	removal of lateral exostosis (maxilla or mandible)	300	300
D7472	removal of torus palatinus	300	300
D7510	incision and drainage of abscess - intraoral soft tissue	0	0
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50	50
D7520	incision and drainage of abscess - extraoral soft tissue	300	300
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	300	300
D7910	suture of recent small wounds up to 5 cm	300	300
D7911	complicated suture - up to 5 cm	300	300
D7912	complicated suture - greater than 5 cm	300	300
D7960	frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	165	165
D7963	frenuloplasty	165	165

Other Services

Iv sedation/general anesthesia is per person, per year. Inhalation of nitrous oxide/analgesia is per person, per visit.

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D9110	palliative (emergency) treatment of dental pain - minor procedure	25	25
D9211	regional block anesthesia	0	0
D9212	trigeminal division block anesthesia	0	0
D9215	local anesthesia in conjunction with operative or surgical procedures	0	0
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	50% up to $40 /visit	50% up to $40 /visit
D9248	non-intravenous conscious sedation	50% up to $40 /visit	50% up to $40 /visit
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20	20
D9410	house/extended care facility call	200	200
D9420	hospital or ambulatory surgical center call	250	250
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	0	0
D9440	office visit - after regularly scheduled hours	25	25
D9951	occlusal adjustment - limited	25	25

Orthodontics

Only medically necessary orthodontia is covered.

	Medically Necessary Orthodontia is for Cleft palate; Cleft palate with cleft lip and the following anomalies: Hemifacial microsmia; Craniosynostosis syndromes; Cleidocranial dental dysplasia; Arthrogryposis; Marfan syndrome. Must be preauthorized.	350	NC

Please call your Dental Health Services Member Service Specialist at 855-495-0905 for a referral to a conveniently located participating orthodontist. Orthodontic models, x-rays, photographs and records are not covered. There may be additional copayments depending on treatment needs.

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Dental Health Services

Exclusions and Limitations

Family Dental HMO SHOP Plan

Orthodontic Exclusions

The following services are not covered by your dental plan:

A. Retreatment of orthodontic cases.
B. Treatment of a case in progress at inception of eligibility.
C. Surgical procedures (including extraction of teeth) incidental of orthodontic treatment.
D. Surgical procedures related to cleft palate, micrognathia or macrognathia.
E. Treatment related to temporomandibular joint (TMJ) disturbances and/or hormonal imblances.
F. Any dental procedure considered within the field of general dentistry including but not limited to: myofunctional therapy; general anesthetics, including intravenous and inhalation sedation dental services of any nature performed in a hospital.
G. Cephalometric x-rays, dental x-rays.
H. Tracings and photographs.
I. Study models.
J. Replacement of lost or broken appliances.
K. Changes in treatment necessitated by an accident of any kind.
L. Payment by Dental Health Services or any special discounted orthodontic copayment for treatment rendered or required after the enrollee is no longer eligible for coverage (i.e. current premium unpaid). The cost of treatment in progress will be prorated and converted to the Orthodontist's actual fee-for service amount.

Orthodontic Limitations

The following are subject to additional charges:

A. Orthodontia is limited to medically necessary orthodontic cases.
B. Services which are compensable under Worker's Compensation or employer liability laws.
C. Malocclusions so severe or mutilated they are not amenable to ideal orthodontic therapy.
D. Most medically-necessary orthodontia requires treatment lasting 24 months. If the contract between Dental Health Services and the enrollee should terminate, copayments will be prorated.

Dental Exclusions

The following services are not covered by your dental plan:

A. Services that are not consistent with professionally recognized standards of practice.
B. Cosmetic services, for appearance only, unless specifically listed.
C. Myofunctional therapy-procedures for training, treating or developing muscles in and around the jaw or mouth including T.M.J. and related diseases, except for occlusal guard.
D. Treatment for malignancies, as well as hereditary, congenital and/or developmental malformations.
E. Dispensing of drugs not normally supplied in a dental office.
F. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.
G. Procedures, appliances or restorations (other than fillings) that are necessary for full mouth rehabilitation, to increase arch vertical dimension, or crown/bridgework requiring more than 10 crowns/pontics. Replacement or stabilization of tooth structure lost through attrition, abrasion or erosion.
H. Procedures performed by a prosthodontist.
I. Fixed bridges for patients under the age of sixteen, in the presence of non-supportive periodontal tissue, when edentulous spaces are bilateral in the same arch, when replacement of more than four teeth in an arch, replacement of missing third molars, or when the prognosis is poor.
J. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.
K. Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.
L. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).
M. Setting of a fracture or dislocation, surgical procedures related to cleft palate, micrognathia or macrognathia, and surgical grafting procedures.
N. Coordination of benefits with another prepaid managed care dental plan.
O. Orthodontic treatment of a case in progress and/or retreatment of ortho cases, excluding Medically Necessary Orthodontia cases which are a covered benefit.
P. Cephalometric x-rays, tracings, photographs and orthodontic study models.
Q. Replacement of lost or broken orthodontic appliances.
R. Changes in orthodontic treatment necessitated by an accident of any kind.
S. Malocclusions so severe or mutilated which are not amenable to ideal orthodontic therapy.
T. Services not specifically listed or listed as NC (not covered) in the Schedule of Covered Services and Copayments.

Dental limitations

Restrictions on benefits are applied to the following services:

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 selects a plan of treatment that is considered optional or unnecessary by the attending dentist, the additional cost is the responsibility of the patient.
C. Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.
D. Full mouth x-rays are limited to one set every two years if needed.
E. Specialty referrals must be pre-approved by Dental Health

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Services for any treatment deemed necessary by the treating participating dentist.

F. Pre-authorization is required for all specialty services.

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

H. Sealants are only a benefit for permanent posterior teeth of children under the age of eighteen.

I. There are additional charges for precious/noble metals (gold).

J. 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 parial is not feasible; or
   2. The denture is unsatisfactory and cannot be made satisfactory.

K. 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.

L. Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.

M. Crowns will be covered only when the teeth cannot be adequately restored with other restorative materials. 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 Dental Health Services.

N. 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.
   1. 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.
   2. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
   3. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

O. I.V. sedation/general anesthesia is per person, per year. Inhalation of nitrous oxide/analgesia is per person, per visit.

Dental Health Services
A Great Reason to Smile sm

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