



California Children's Dental PPO

This Schedule of Benefits, along with the Exclusions and Limitations describe the benefits of the Children's Dental PPO Plan. Please review closely to understand all benefits, exclusions and limitations.

Member Cost Share amounts describe the Enrollee's out of pocket costs.

EHB HIGH PLAN*	Member Cost Share In-Network	Covered Percentage In Network	Member Cost Share Out-of-Network**	Covered Percentage Out-of-Network**
Diagnostic and Preventive Exams, Cleanings, Fluoride, Sealants, X-rays and Consultations	0%	100%	0%	100%
Basic Services Amalgam Fillings, Composite Fillings (Anterior Only) and Emergency Palliative	20%	80%	20%	80%
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics, and Oral Surgery	50%	50%	50%	50%
Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	50%	50%	50%	50%
Deductible (Waived for Diagnostic & Preventive) (per person)	\$65	N/A	\$65	N/A
Family Deductible*** (Waived for Diagnostic & Preventive) (2+ children)	\$130	N/A	\$130	N/A
Out of Pocket Maximum (OOP) (per person)	\$350	N/A	N/A	N/A
Family Out of Pocket Maximum*** (OOP) (2+ children)	\$700	N/A	N/A	N/A
Annual Maximum	N/A	N/A	N/A	N/A
Ortho Lifetime Maximum	N/A	N/A	N/A	N/A
Waiting Period	N/A	N/A	N/A	N/A

* This plan is available for individuals up to age 19.

**Benefits are based on the Usual and Customary charges of the majority of dentists in the same geographic area.

***2 family members must each meet the single deductible and out of pocket maximum in a plan year. Once fulfilled the family maximum has been met and will not be applied to additional family members.



California Children's Dental PPO

CLASSES OF COVERED SERVICES AND SUPPLIES (Individuals up to age 19)

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

Class I: Preventive Dental Services

Diagnostic and Preventive Benefits

Benefit includes:

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

Limitations

X-Rays are limited as follows:

- Exams are limited to two in a 12 month period
- Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months

- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
- Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period
- Fluoride treatments are limited to two in a 12 month period
- Dental sealant treatments are limited to permanent first and second molars only

Class II: Basic Dental Services

Restorative Dentistry

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

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

Class III: Major Dental Services

Oral Surgery

Oral Surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies

California Children's Dental PPO

- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

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

Endodontics

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

Limitations

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

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

Periodontics

Periodontic benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis

- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

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

Crown and Fixed Bridge

Crown and fixed bridge benefits include:

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

Limitations

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every sixty (60) consecutive months, except when the crown is no longer functional as determined by the dental plan
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling



California Children's Dental PPO

- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case.
 - If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic
- Fixed bridges are optional when provided in connection with a partial denture on the same arch
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair
- The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment

Removable Prosthetics

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair

- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space Maintainer
- Stayplate

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within sixty (60) consecutive months, unless:
 1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
 2. The denture is unsatisfactory and cannot be made satisfactory
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional
- Full upper and/or lower dentures are not to be replaced within sixty (60) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges
- Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months
- Tissue conditioning is limited to two (2) per denture
- Implants are considered an optional benefit



California Children's Dental PPO

- Stayplates are a benefit only when used as anterior space maintainers for children

Class IV: Medically Necessary Orthodontia

Orthodontics

Medically necessary orthodontia is treatment to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Other Benefits

Other dental benefits include:

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

General Exclusions

Covered Services and Supplies do not include:

1. Treatment which is:
 - a. not included in the list of Covered Services and Supplies except Medically Necessary Orthodontia;
 - b. not Dentally Necessary; or
 - c. Experimental in nature.
2. Any Charges which are:
 - a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Plan will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
 - b. Not imposed against the person or for which the person is not liable.
3. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Plan that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
3. Services or supplies resulting from or in the course of Your regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Plan of all such benefits.
4. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is:
 - a. a Close Relative or a person who ordinarily resides with You or a Dependent;
 - b. an Employee of the Employer;
 - c. the Employer.
5. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
6. Services and supplies provided primarily for cosmetic purposes.
7. Services and supplies obtained while outside of the United States, except for Emergency Dental Care.
8. Correction of congenital conditions or replacement of congenitally missing permanent teeth, regardless of the length of time the deciduous tooth is retained.
9. Diagnostic casts.



California Children's Dental PPO

10. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
11. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
12. Restorative procedures, root canals and appliances, which are provided because of attrition, abrasion, erosion, abfraction, wear, or for cosmetic purposes in the absence of decay.
13. Veneers
14. Appliances, inlays, cast restorations, crowns and bridges, or other laboratory prepared restorations used primarily for the purpose of splinting (temporary tooth stabilization).
15. Replacement of a lost or stolen Appliance or Prosthesis.
16. Replacement of stayplates.
17. Extraction of pathology-free teeth, including supernumerary teeth (unless for medically necessary orthodontia)
18. Socket preservation bone graphs
19. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
20. Treatment for a jaw fracture.
21. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
22. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
23. Oral sedation and nitrous oxide analgesia are not covered.
24. Therapeutic drug injection.
25. Charges for completion of claim forms by dental providers.
26. Missed dental appointments.
27. The difference in cost between a covered service and an optional service. For instance, when an amalgam is an appropriate restorative treatment and a crown is opted instead. The amount of the benefit payment will be for the amalgam only.