California Dental Network

A DentaQuest company

Group Subscriber Agreement
Combined Evidence of Coverage
And
Disclosure Form

California Dental Network Family Dental HMO

This Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form contains the exact terms and conditions of coverage for the California Dental Network Family Dental HMO.

Upon request, a copy of this Combined Evidence of Coverage and Disclosure Form shall be provided to a non-covered parent having custody of a child.

This Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form should be read completely and carefully, and individuals with special health care needs should carefully read those sections that apply to them.

Applicants may receive additional information about the benefits of the Plan by calling (949) 830-1600, Toll-free 1-855-425-4164.

The dental health plan benefits and coverage matrix is located at the end of this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

California Dental Network Family Dental HMO Summary 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.

Family Dental HMO	Children (up to Age 19)	Adult (Age 19 and older)
Deductibles	None	None
Actuarial Value	84.80%	Not Calculated
Out of Pocket Maximums	Individual Child- $350	Not Applicable
	Two or more Children in a family - $700	Not Applicable
Office Copay	No Charge	No Charge
Waiting Period	None	None
Annual Benefit Limit	None	None

Professional Services	Copayments vary by procedure and can be found on the *2020 Member Copayment Schedule,* included. Categories of services include:		
Diagnostic & Preventive Services:	Oral Exam	No Charge	No Charge
	Preventive-Cleaning	No Charge	No Charge
	Preventive-X-ray	No Charge	No Charge
	Sealants Per Tooth	No Charge	No Charge
	Topical Fluoride Application	No Charge	No Charge
	Space Maintainers, Fixed	No Charge	No Charge
Basic Services	Restorative Procedures	See *2020 Member Copayment Schedule*	See *2020 Member Copayment Schedule*
	Periodontal Maintenance Procedures		
	Adult Periodontics (other than maintenance)		
	Adult Endodontics		
Major Services	Periodontics (other than maintenance)	See 2020 Member Copayment Schedule	See 2020 Member Copayment Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontics	Medically Necessary Orthodontia	$350.00	Not Covered

Endnotes to 2020 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
5) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

6) Tooth whitening, adult orthodontia, implants, veneers, and adult services noted as Not Covered on the Copayment Schedule are not covered services.
7) The six month waiting period for major services must be waived upon a member's provision of proof of prior comprehensive dental coverage. This waiting period shall be prorated on a one to one monthly basis upon a member's provision of proof of prior comprehensive dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month waiting period would no longer occur. Dental services obtained via a discount health plan are not considered "comprehensive" dental coverage for purposes of counting towards the waiting period.

WELCOME

CDN, Inc. (CDN) combines comprehensive dental coverage with a number of cost-saving features for you and your family. Many preventive procedures are covered at no cost to you, and you will experience significant

savings based upon our copayments for covered services. There are no claim forms to complete, and no deductibles or lifetime benefit maximums.

I. DEFINITIONS

Act means the Knox-Keene Health Care Service Plan Act of 1975 (California Health and Safety Code Sections 1340 et seq.) as amended.

Agreement or Group Subscriber Agreement means this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form by which its terms limits the eligibility of Subscribers and enrollees to a specified Group. Your completed Enrollment Application and schedule of Principal Benefits and Coverage under which you are enrolled along with this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form, will constitute the entire Agreement.

Benefits or Coverage mean the health care services available under this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and the Benefit Schedule under which you are enrolled.

Benefit Schedule means the schedule of Principal Benefits & Coverage which list the Benefits specifically covered under each plan and denotes the copayments required by you.

Cal-COBRA: State law requiring an individual in a small group of 2-19 members to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage.

Capitation means a monthly or annual periodic payment based on a fixed or predetermined basis that is paid to the Participating Dentist.

Child means eligible children including 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.

COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1986, enacted April 7, 1986. A federal law requiring an individual to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage.

Copayment means a fixed payment for a covered service, paid when an individual receives service, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

Dependents shall mean the lawful spouse, domestic partner, and dependent children of a Member, as defined herein under the section entitled Eligible Dependents. Please see Section IV. "Eligible Dependents" for more information in Dependents.

Emergency Dental Care means service required for immediate alleviation of acute symptoms associated with an emergency dental condition..

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably expected to result in any of the following:.

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

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

Exclusion means any provision of this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form whereby Coverage for a specified hazard or condition is not covered by CDN or the Participating Dentist.

Group means any employer, labor union or labor management trust fund, or other Subscriber Group.

Limitation means any provision other than an Exclusion which restricts Coverage under this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

Member means the Subscriber or any eligible Dependent who is enrolled and whose premiums are paid under this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

Out-of-Pocket Maximum (OOPM) means the maximum amount of money that a pediatric age (child up to age 19) enrollee must pay for benefits during a calendar year. Out-of-Pocket Maximum applies only to the Essential Health Benefits for pediatric (children up to age 19) enrollees. Copayments for covered services that pediatric enrollees (children up to age 19) received from a participating dentist accumulate through the plan year toward the 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 the dental plan doesn't cover. After the pediatric age enrollee reaches their OOPM, they will have no further copayments for benefits for the remainder of the calendar year. If more than one pediatric age enrollee (meaning multiple children in one family) is covered under the contract, the financial obligation for benefits is not more than the OOPM for multiple children. 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.

Plan is the CDN Plan and shall include those Benefits, Coverage and other charges as set forth herein and in the Benefit Schedule.

Participating Dentist means a licensed California dentist who has contracted with CDN as a general practitioner, and shall include any hygienists and technicians recognized by the dental profession who assist and act under the supervision of the dentist, and/or a specialist to render services to Members in accordance with the provisions of the CDN Agreement under which a Member is enrolled. The names, locations, hours, services, and other information regarding CDN's Participating Dentist facilities may be obtained by contacting CDN's office or the individual Participating Dentist.

Pediatric Dental Benefits are 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 up to age 19.

Regulations means those Regulations promulgated and officially adopted by the California Department of Managed Health Care.

Special enrollments are 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.

Specialist means a dentist who is responsible for the specific specialized dental care of a Member in one specific field of dentistry, such as endodontics, periodontics, pedodontics, oral surgery or orthodontics, where the Member is referred by CDN.

Subscriber is the person who has entered into this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and who is responsible for the premium payment to CDN.

Urgent Dental Care means care required to prevent serious deterioration in a Member's health, following the onset of an unforeseen condition. Urgent care is care required within 24 to 72 hours, and includes only services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed.

II. HOW TO USE CDN

In addition to this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and a Benefit Schedule, CDN issues each Member an Identification Card with the telephone number and address of the selected dental office. Upon request, an identification card will be issued to the non-covered parent having custody of a child. This I.D. Card is to be presented at the time that services are to be rendered by the Participating Dentist.

A complete list of covered services is enclosed in the Benefit Schedule along with the required copayments. Services specifically excluded from Members' Coverage are found in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-panel dentist or non-panel specialist are not covered. Refer to section XIV. SPECIALIST REFERRALS for more information on obtaining care from a plan contracted specialist. Under certain emergency situations as explained under the section titled EMERGENCY AND URGENT DENTAL CARE, services by a non-contracted general dentist may be covered.

III. ELIGIBILITY

A Member's Group and the Group Subscriber Agreement shall determine who is eligible to participate and who is actually participating in CDN's Plan. Any disputes or inquiries regarding eligibility, renewal, reinstatement and the like, should be directed to the Member's Group or CDN as appropriate.

Dependents may 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 circumstances. Visit www.coveredca.com for more information.

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 CDN coverage will begin once the enrollment process is complete, premium payment is received, and the effective date is communicated to CDN by Covered California.

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.

Subscribers and eligible Dependents must either live or work within the CDN approved service are in order to be eligible for Benefits hereunder. When payment and application are received and approved by the 20th of the month, eligibility will commence on the first of the following month.

IV. ELIGIBLE DEPENDENTS

A Member's eligible Dependents are their lawful spouse and Dependent children. An eligible dependent shall include a) any child born out of wedlock, b) a child not claimed as a dependent on the parents' federal income tax return and c) a child who does not reside with the parent or within the Plan's service area. All newborn infants' Coverage shall commence from and after the moment of birth. Adopted children and stepchildren shall

be covered from and after the date of placement. Except as stated above, Dependents shall be eligible for coverage on the first day of the next month from the date the Subscriber is eligible for coverage, or on the day the Subscriber acquires such Dependent, whichever is later. In a case where a parent is eligible for the coverage, the Plan shall a) permit the parent to enroll under the Plan any child who is otherwise eligible to enroll for that coverage, without regard to any enrollment period restrictions, b) enroll the child, if parent fails to do so, upon presentation of the court order or request by the district attorney, the other parent or person having custody.

California has legalized registered domestic partnerships for same-sex and opposite-sex couples. In order for two individuals to be considered domestic partners in California, they must be in an intimate, committed relationship and file a Declaration of Domestic Partnership with the California Secretary of State. When the declaration is filed, the following requirements must also be fulfilled:

- Each individual is at least 18 years of age, unless consent is given from the minor's parent or guardian;
- Neither individual is related by blood in any way that would prevent marriage in the state;
- Neither individual is married, or in another domestic partnership with another individual;
- Both individuals are of the same sex or, if the individuals are of the opposite-sex, at least one person is over 62 years of age; and
- Both individuals are capable of consenting to a domestic partnership.

Dependents shall also include all children under the age of 26 years.
Coverage shall not terminate at age 26 while a Dependent child is and continues to be:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the subscriber for support and maintenance provided the subscriber furnishes proof of such incapacity and dependency to CDN within 31 days of the child attaining the limiting age set forth above, and every two years thereafter, if requested by CDN.

In a case where a parent is required by a court or administrative order to provide coverage for a child the Plan shall not disenroll or eliminate coverage unless a) the employer has eliminated coverage for all employees, b) the Plan is provided with satisfactory written evidence that either the court order or administrative order is no longer in effect, or c) the child is or will be enrolled in another or comparable plan that will take effect no later than the effective date of the child's disenrollment.

V. CHOICE OF PARTICIPATING DENTIST AND PARTICIPATING DENTIST COMPENSATION

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUPS OF PARTICIPATING DENTISTS DENTAL CARE MAY BE OBTAINED.

You may select any CDN Participating Dentist for you and your family's dental care. All family members MUST use the same office and the Plan subscriber must live or work within CDN's service area within California. A request to change dental office may be done by contacting CDN toll-free at 1-855-425-4164 or by requesting such in writing to CDN's office. Any such change will become effective on the first day of the month following CDN's approval if request is received by CDN by the 20th of the month. CDN may require up to 30 days to process any such request. All Member fees and Copayments must be paid in full prior to such a transfer.

In consideration of the performance by the Participating Dentist of services made available and/or rendered to Members pursuant to this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form and the schedule of Principal Benefits and Coverage, the compensation to the Participating Dentist shall be:

- The copayments paid directly to the CDN Participating Dentist by the Member as set forth in this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure form, and/or
- The Capitation paid to the Participating Dentist by CDN and/or
- Any direct reimbursement by CDN based on specific services provided as allowed by our Dental Services Agreement with the Participating Dentist.

CDN does not have, in any contract and/or agreement with a Participating Dentist or other licensed health care professional, any such compensation agreement term that includes a specific payment or compensation made directly, in any type or form, as an inducement to deny, reduce, limit or delay, any specific, medically necessary, or appropriate services.

VI. SECOND OPINION POLICY

It is the policy of CDN that a second opinion obtained from a participating panel provider will be a covered benefit. The covered benefit will need an approval from the Plan. A second opinion is encouraged as a positive component of quality of care.

General Practice Second Opinion

A request for a second opinion may be processed if one or more of the following conditions are evident:

- Member wishes affirmation of a complex or extensive treatment plan, alternative treatment plan, or clarification of a treatment plan or procedure.
- Member has a question about correctness of a diagnosis of a procedure or treatment plan.
- Member questions progress and successful outcome of a treatment plan.
- Plan requires a second opinion as part of the resolution of a Member's grievance.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to a CDN Dental Director for consideration.

Members may obtain a second opinion by contacting CDN at 1-855-425-4164. The Member will be given the names of providers in their area to select a second opinion provider. If the Member opts not to accept one of the contracted providers and wishes to go out of the network, it is not a covered benefit. The provider of choice will be notified by the Plan of the Member's need for a second opinion and the applicable co-payment. The Member will be responsible for obtaining an appointment from the second opinion provider.

The Plan representative will complete a second opinion form. X-rays and records from the current provider will be obtained, and along with the form, be sent to the second opinion provider.

Contracting providers have agreed in their contract to participate in the Quality Assurance activities of the Plan. The provision of a second opinion is considered to be part of the Plan's Quality Assurance Activities, therefore all contracting providers agree to:

- Provide copies of necessary records and radiographs to the Plan (at no charge to the Members, Plan or second opinion provider) for review by the second opinion provider.

- To agree to provide second opinion evaluation to Members at copayment upon approval of the second opinion request by the Plan, and to make the results of their evaluation available to the referring provider, the Member, and the Plan.

Second opinion providers may elect to accept a Member seeking a transfer but are not obligated to do so. Transfers must be mutually agreed to the second opinion provider and the Member seeking the second opinion.

Specialty Second Opinion

Specialty procedures incorporated in a treatment plan may require a specialty second opinion. These would be processed in the same manner as a general practice second opinion with the same guideline.

Orthodontic Second Opinion

In the case of an Orthodontic second opinion, it will be processed the same as a general except, the following conditions must be evident:

- Questions about extractions of teeth to effect completion of treatment versus non-extraction of teeth.
- Questions on length of time of treatment.
- Questions about facial changes, growth and development.
- Questions about initiation of treatment, interceptive treatment, removable versus fixed therapy.
- Questions about multiple providers treating case vs. one provider reporting outcomes.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to the Dental Director for consideration.

Denials

Conditions under which a second opinion may be denied:

- Member is not eligible or the Plan has been terminated.
- Member has completed treatment. Any second thoughts at this point are deemed a grievance.
- Member has consented to treatment. Dissatisfaction with the provider due to attitude or other personality discomforts (other than treatment plan).
- Treatment plan has been accepted by patient, treatment in progress and patient is not fulfilling agreements financially, appointments, follow-up, home care, etc.

Emergency Second Opinion

When a Member's condition is such that the Member faces imminent and serious threat to his or her health (including, but not limited to, potential loss of life, limb, or other body function), the request for a second opinion will be authorized within 72 hours of the Plan's receipt of the request, whenever possible.

VII. FACILITIES

CDN's participating dental offices are open during normal business hours and some offices are open limited Saturday hours. Please remember; if you cannot keep your scheduled appointment, you must notify your dental office at least 24 hours in advance or you may be responsible for a broken appointment fee (please refer to your Benefit Schedule).

VIII. PREPAYMENT FEE

Subscribers and/or Groups agree that CDN shall provide services set forth in this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form at the rates specified in the Enrollment Application and the Benefit Schedule upon payment of the monthly or annual Prepayment Fee. Subscriber should consult the contract holder or Agreement for specific information regarding any sums to be paid or withheld from the Subscriber's salary or to be paid by subscriber. The Prepayment Fee shall be sent to CDN.

IX. LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between CDN and a Participating Dentist shall provide that in the event that CDN fails to pay the Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by CDN.
In the event that CDN does not pay non-contracting Participating Dentists, the Member may be liable to the non-contracting Participating Dentist for costs of services rendered.

Members will be responsible for all supplementary charges, including copayments, deductibles and procedures not covered as Plan Benefits.

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a participating dental Participating Dentist 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 the patient with a treatment plan that includes each anticipated service. If you would like more information about dental coverage options, you may call member services at 1-855-425-4164 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

X. COORDINATION OF BENEFITS

In the event a member is covered under another plan or policy which provides coverage, benefits or services (plan) that are covered benefits under this dental plan, then the benefits of this plan shall be coordinated with the other plan according to regulations on "Coordination of Benefits". Covered California's standard benefit design requires that stand alone dental plans offering the pediatric dental essential health benefit, such as this CDN plan, whether as a separate benefit or combined with a family dental benefit, cover benefits as a secondary dental benefit plan payer. This means that the primary dental benefit payer is a health plan purchased through Covered California which includes pediatric dental essential health benefits.

Your primary dental benefit plan will pay the maximum amount required by its plan contract with you when your primary dental benefit plan is coordinating its benefits with CDN. This means that CDN will pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage when a primary dental benefits plan is coordinating benefits with your CDN plan, or your total out-of- pocket cost payable under the primary dental benefit plan for benefits covered under your CDN plan.

These regulations determine which plan is primary and which is secondary under various circumstances. Generally, they result in a group plan being primary over an individual plan and that a plan covering the member as a subscriber is primary over a plan covering the member as a dependent. Typically, Coordination of Benefits will result in the following:

If the other coverage is a group indemnity plan:

- If the group indemnity coverage is primary, the provider will usually bill the carrier for their Usual and Customary Fees, and the member will be charged the copayment under the secondary plan less the amount received from the primary coverage.
- If the group indemnity coverage is secondary, the provider will bill the carrier for the amount of copayments under the primary plan, and the member will be responsible for the copayments under the primary plan less the amount paid by the secondary carrier.

If the other coverage is a prepaid plan:

- If the provider participates in both plans, the member should be charged the lower copayment(s) of the two plans.
- If the provider does not participate in both plans, the plan that the provider participates in will be primary, and the other plan will typically deny coverage because the member received services from a non-participating provider.

Members may not receive benefits for more than their out of pocket costs for the services provided as a result of Coordination of Benefits.

A copy of the Coordination of Benefits regulations may be obtained from CDN.
The Plan and/or its treating providers reserve the right to recover the cost or value, as set forth in Section 3040 of the Civil Code, of covered services provided to a Member that resulted from or were caused by third parties who are subsequently determined to be responsible for the injury to the Member.

XI. OUT-OF-POCKET MAXIMUM (OOPM)

Out-of-Pocket Maximum (OOPM) is the maximum amount of money that a pediatric age (child up to age 19) enrollee must pay for benefits during a calendar year before their plan benefits are paid in full. Out-of-Pocket Maximum applies only to the Essential Health Benefits for pediatric enrollees (children up to age 19). Copayments for covered services that pediatric enrollees (children up to age 19) received from a participating dentist accumulate through the plan year toward the Out-of-Pocket Maximum. Please consult the included Member Copayment Schedule for complete information on covered services. OOPM never includes premium, prescriptions, or dental care the dental plan doesn't cover. After the pediatric age enrollee reaches their OOPM, they will have no further copayments for benefits for the remainder of the calendar year.

If more than one pediatric age enrollee (meaning multiple children up to age 19 in one family) are covered under the contract, the financial obligation for benefits is not more than the OOPM for multiple children. This means that a family of two or more children is subject to the Family OOPM. Once the amount paid by all pediatric age enrollees equals the Family OOPM no further copayments will be required by any of the pediatric age enrollees for the remainder of the calendar year.

CDN monitors out-of-pocket payments over the course of the plan year. When those payments reach the Out-of-Pocket Maximum for a member's plan, we will send a letter to both the member and the member's selected Participating Dentist to ensure that they are not responsible for copayments for future services.

CDN encourages members to retain receipts for all of the services received that are covered under the CDN plan through the plan year to track out-of-pocket expenses. Members should always ask their Participating Dentist for an itemized receipt of services provided during their visit.

XII. EMERGENCY AND URGENT DENTAL CARE

Emergency and urgent dental care is covered 24 hours a day, seven days a week, for all Members. Emergency dental Care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is care

required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefits is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration. Please contact your Participating Dentist for emergency or urgent dental care. If your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-855-425-4164.

In the case of an after-hours emergency, and your selected dental provider is unavailable, you may obtain emergency or urgent service from any licensed dentist. You need only submit to CDN, at the address listed herein, the bill incurred as a result of the dental emergency, evidence of payment and a brief explanation of the unavailability of your Provider. A non-covered parent of a covered child may submit a claim for emergency care without the approval of the covered parent, in such case the non-covered parent will be reimbursed. Upon verification of your Provider's unavailability, CDN will reimburse you for the cost of emergency or urgent services, less any applicable copayment.

Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

XIII. REIMBURSEMENT PROVISION FOR OUT-OF-AREA CARE

You are covered for emergency and urgent dental care. If you are away from your assigned participating provider, you may contact CDN for referral to another contracted dentist that can treat your urgent or emergency condition. If you are out of the area, it is after CDN's normal business hours, or you cannot contact CDN to redirect you to another contracted dentist, contact any licensed dentist to receive emergency or urgent care. You are required to submit a detailed statement from the treating dentist with a list of all the services provided. Member claims must be filed within 60 days and we will reimburse Members within 30 days for any emergency or urgent care expenses. A non-covered parent of a covered child may submit a claim for an out-of-area emergency without the approval of the covered parent, in that case the non-covered parent will be reimbursed. Submit all claims to CDN at this address:

California Dental Network, Inc.
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653

Emergency dental care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is treatment required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for emergency or urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding, or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefit is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration. Submit all claims for reimbursement to CDN at the address listed herein.

XIV. SPECIALIST REFERRALS

If your Participating Dentist decides that you need the services of a specialist, they will request Prior Authorization for a referral to a CDN Specialist. CDN will send you a letter of treatment authorization, including the name, address, and phone number of your assigned CDN specialist. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by CDN to make the determination. If an emergency referral is required, your Primary Dentist will contact CDN and prompt arrangements will be made for specialty treatment. Emergency referrals are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by CDN to make the determination. Your Primary Dentist will be informed of CDN's decision within 24 hours of the determination. Both the general provider and the patient will be notified in writing of approval or denial. If you have questions about how a certain service is approved, call CDN toll-free at 1-855-425-4164- If you are deaf or hard of hearing, dial 711 for the California Relay Service. We will be happy to send you a general explanation of how that type of decision is made or send you a general explanation of the overall approval process if you request it.

If you request services from any specialist without prior written approval, you will be responsible for payment.

XV. CONTINUATION OF COVERAGE ACUTE CONDITION OR SERIOUS CHRONIC CONDITION

At the request of the enrollee, the Plan will, under certain circumstances, arrange for continuation of covered services rendered by a terminated Participating Dentist to an enrollee who is undergoing a course of treatment from a terminated Participating Dentist for an acute condition or serious chronic condition. In the event the enrollee and the terminated Participating Dentist qualify, the Plan will furnish the dental services on a timely and appropriate basis for up to 90-days or longer if necessary, for a safe transfer to another Participating Dentist as determined by the Plan in consultation with the terminated Participating Dentist, consistent with good professional practice.

The payment of copayments, deductibles, or other cost sharing components by the enrollee during the period of continuation of care with a terminated Participating Dentist shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a Participating Dentist currently contracted with or employed by the Plan. The Plan will not cover services or provide benefits that are not otherwise covered under the terms and condition of the Plan contract.

For the purpose of this section:

"Terminated Participating Dentist" means a Participating Dentist whose contract to provide services to Plan enrollees is terminated or not renewed by the plan or one of the plan's contracting Participating Dentist groups. A terminated Participating Dentist is not a Participating Dentist who voluntarily leaves the plan or contracted Participating Dentist group.

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

"Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(a) Persists with full cure or worsens over an extended period of time.
(b) Requires ongoing treatment to maintain remission or prevent deterioration.

To request consideration of the continuance of services from a terminated Participating Dentist because you have an acute or serious chronic condition, call or write the Plan.

XVI. LANGUAGE AND COMMUNICATION ASSISTANCE

If English is not your first language, CDN provides interpretation services and translation of certain written materials. If you have a preferred language, or need language assistance, please notify us of your personal language needs by calling CDN at 1-855-425-4164.

If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance services by calling CDN at 1-855-425-4164.

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-425-4164.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-425-4164。
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-425-4164.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-425-4164.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-425-4164 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-425-4164.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-425-4164.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-425-4164.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-425-4164 まで、お電話にてご連絡ください。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-425-4164.
Farsi	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-425-4164 تماس بگیرید.
Hindi	ध्यान दें: यदि आप स्पैनिश बोलते हैं, तो आपके पास नि: शुल्क भाषा सहायता सेवाएं हैं। 1-855-425-4164 पर कॉल करें
Gujarati	**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-855-425-4164.
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-425-4164.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-425-4164.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-

	855-425-4164 'ਤੇ ਕਾਲ ਕਰੋ।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-425-4164.
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-425-4164

XVII. BENEFITS, EXCLUSIONS, AND LIMITATIONS FOR PEDIATRIC MEMBERS

California Dental Network Covered California Family Dental HMO Benefits are set forth in the attached list of covered procedures and are subject to the applicable member cost (copayment) in the list, when provided by a CDN Participating Dental Participating Dentist and subject to the Exclusions and Limitations contained herein. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable.

Coverage of the pediatric dental essential health benefits is limited to dependent children up to age 19.

Benefits and Limits for Diagnostic Services:

- Periodic oral evaluation (D0120): once every six months, per provider.
- Limited oral evaluation, problem focused (D0140): once per patient per provider.
- Comprehensive oral evaluation (D0150): once per patient per provider for the initial evaluation.
- Detailed and extensive oral evaluation (D0160): problem focused, by repot, once per patient per provider.
- Re-evaluation, limited, problem focused (not post-operative visit) (D0170) : a benefit for the ongoing symptomatic care of temporomandibular joint dysfunction; up to six times in a three month period, up to a maximum of 12 in a 12 month period.
- Radiographs (X-rays), Intraoral, complete series (including bitewings) (D0210): once per provider every 36 months.
- Radiographs (X-rays), Intraoral, periapical first film (D0220): a benefit to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, periapical each additional film (D0230): a benefit to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, occlusal film (D0240): A benefit up to a maximum of two in a six-month period per provider.
- Radiographs (X-rays), Extraoral (D0250): A benefit once per date of service.
- Radiographs (X-rays), bitewing , single film (D0270): A benefit once per date of service.
- Radiographs (X-rays), bitewings, two films (D0272): A benefit once every six months per provider.
- Radiographs (X-rays), bitewings, four films (D0274): A benefit once every six months per provider.
- Radiographs (X-rays) Temporomandibular joint arthrogram, including injection (D0320): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.
- Radiographs (X-rays) Tomographic survey (D0322): A benefit twice in a 12 month period per provider.
- Radiographs (X-rays) Panoramic film (D0330): A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).

- Radiographs (X-rays), Cephalometric radiographic image (D0340): A benefit twice in a 12 month period per provider.
- Oral/Facial Photographic Images 1st (D0350): A benefit up to a maximum of four per date of service.
- Diagnostic casts (D0470): A benefit once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment, for patients under the age of 21, for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

Benefits and Limits for Preventive Services:

- Prophylaxis, adult (D1110): A benefit once in a twelve-month period.
- Prophylaxis, child (D1120): A benefit once in a six- month period for patients under the age of 21.
- Topical fluoride varnish (D1206): A benefit once in a six month period for patients under the age of 21; once in a 12 month period for patients age 21 or older.
- Topical application of fluoride (D1208): A benefit once in a six month period for patients under the age of 21; once in a 12 month period for patients age 21 or older.
- Sealant, per tooth (D1351): A benefit, for first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth (D1352): A benefit for first, second and third permanent molars that occupy the second molar position; only for an active cavitated lesion in a pit or fissure that does not cross the DEJ; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Interim caries arresting medicament application—per tooth (D1354): Conservative treatment of an active asymptomatic carious lesion by topical application of a caries arresting or inhibiting medicament without removing sound tooth structure. A benefit once per tooth per 6 months per provider. Not a benefit when performed on the same date of service with a permanent restoration or crown for same tooth or on root canal or pulpotomy treated teeth.
- Space maintainer, fixed, unilateral (D1510): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral, maxillary (D1516): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral, mandibular (D1517): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, removable, unilateral (D1520): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires
- Space maintainer, removable, bilateral, maxillary (D1526): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

- Space maintainer, removable, bilateral, mandibular (D1527): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Re-cementation of space maintainer (D1550): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.

Benefits and Limits for Restorative Services:

- Primary teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 12 month period.
- Permanent teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 36 month period.
- Primary teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 12 month period, each unique tooth surface is only payable once per tooth per date of service.
- Permanent teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 36 month period, each unique tooth surface is only payable once per tooth per date of service
- Primary teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 12 month period.
- Permanent teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 36 month period
- Primary teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 12 month period.
- Permanent teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 36 month period.
- Crown, resin based composite (indirect), permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2710): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, resin based composite (indirect), permanent posterior teeth, age 21 or older, (D2710): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; for use as a temporary crown.
- Crown, 3/4 resin-based composite (indirect), permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2712): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; or for use as a temporary crown.
- Crown, 3/4 resin-based composite (indirect), permanent posterior teeth, age 21 or older, (D2712): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar

occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; for use as a temporary crown.

- Crown, resin with predominantly base metal, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2721): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, resin with predominantly base metal, permanent posterior teeth, age 21 or older, (D2721): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; for use as a temporary crown.
- Crown, porcelain/ceramic substrate, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20), (D2740): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain/ceramic substrate, permanent posterior teeth, age 21 or older, (D2740): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; for use as a temporary crown.
- Crown, porcelain fused to predominantly base metal, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2751): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain fused to predominantly base metal, permanent posterior teeth age 21 and older (D2751): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 cast predominantly base metal, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20)(D2781): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 cast predominantly base metal, permanent posterior teeth age 21 and older (D2781): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 porcelain/ceramic, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2783): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 porcelain/ceramic, permanent posterior teeth age 21 and older (D2783): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan

includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

- Crown, full cast predominantly base metal, permanent anterior (age 13 and older) and posterior teeth (age 13 through 20) (D2791): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, full cast predominantly base metal, permanent posterior teeth age 21 and older (D2791): A benefit once in a five-year period; only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Recement inlay, onlay or partial coverage restoration (2910): A benefit once in a 12 month period, per provider.
- Recement crown (D2920): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Prefabricated porcelain/ceramic crown - primary tooth (D2929): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - primary tooth (D2930): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - permanent tooth (D2931): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Primary teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 12 month period.
- Permanent teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Protective restoration (D2940): A benefit once per tooth in a six-month period, per provider. Not a benefit when performed on the same date of service with a permanent restoration or crown, for same tooth; on root canal treated teeth.
- Pin retention - per tooth, in addition to restoration (D2951): A benefit for permanent teeth only; when billed with an amalgam or composite restoration on the same date of service; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp; or for an anterior restoration when extensive coronal destruction involves the incisal angle.
- Post and core in addition to crown, indirectly fabricated (D2952): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Prefabricated post and core in addition to crown (D2954): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Crown repair necessitated by restorative material failure (D2980): A benefit for laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

Benefits and Limits for Endodontic Services:

- Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament (D3220): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; for a primary tooth with a necrotic pulp or a periapical lesion; for a primary tooth that is non-restorable; or for a permanent tooth.

- Pulpal debridement, primary and permanent teeth (D3221): A benefit for permanent teeth or for over-retained primary teeth with no permanent successor; once per tooth.
- Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development (D3222): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Pulpal therapy (resorbable filling) – anterior, primary tooth (D3230), or posterior, primary tooth (D3240), (excluding final restoration): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; or with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
- Root canal therapy, anterior tooth (D3310) (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
- Root canal therapy, bicuspid tooth (D3320), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
- Root canal therapy, molar (excluding final restoration) (D3330): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Retreatment of previous root canal therapy – anterior (D3346), bicuspid (D3347): Not a benefit to the original provider within 12 months of initial treatment.
- Retreatment of previous root canal therapy – molar (D3348): Not a benefit to the original provider within 12 months of initial treatment; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests
- Apexification/ recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.) (D3351): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apexification/recalcification – interim (D3352): A benefit once per permanent tooth; only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apicoectomy/periradicular surgery – anterior (D3410): A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - bicuspid (first root) (D3421): A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - molar (first root) (D3425): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar

position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

- Apicoectomy / periradicular surgery - molar, each additional root (D3426): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

Benefits and Limits for Periodontic Services:

- Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210) or one to three contiguous teeth, or tooth bounded spaces per quadrant (D4211): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant (D4260): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant (D4261): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Periodontal scaling and root planing - four or more teeth per quadrant (D4341) or one to three teeth per quadrant (D4342): A benefit for patients age 13 or older; each once per quadrant every 24 months.
- Periodontal maintenance (D4910): A benefit only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); only when preceded by a periodontal scaling and root planing (D4341- D4342); only after completion of all necessary scaling and root planings; once in a calendar quarter; only in the 24 month period following the last scaling and root planing.
- Unscheduled dressing change (by someone other than treating dentist) (D4920): for patients age 13 or older; once per patient per provider; within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)

Benefits and Limits for Prosthodontic Services:

- Prosthodontic services provided solely for cosmetic purposes are not a benefit.
- Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
- Spare or backup dentures are not a benefit.
- Evaluation of a denture on a maintenance basis is not a benefit.
- Complete denture – upper (D5110), lower (D5120): Each a benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
- Immediate denture – upper (D5130), lower (D5140): Each a benefit once per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
- Partial denture - resin based with conventional clasps, rests and teeth, upper (D5211) or lower (D5212): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Partial denture - cast metal resin based with conventional clasps, rests and teeth, upper (D5213) or lower (D5214): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd

permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.

- Adjust complete denture - upper (D5410) or lower (D5411): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit: same date of service or within six months of the date of service of a complete denture- maxillary (D5110) mandibular (D5120), immediate denture- maxillary (D5130) mandibular (D5140) or overdenture-maxillary (D5863) or mandibular (D5865); same date of service or within six months of the date of service of a reline complete denture (chairside) maxillary (D5730) mandibular (D5731), reline complete denture (laboratory) maxillary (D5750) mandibular (D5751) and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair broken complete denture base (D5511 or D5512) and replace missing or broken teeth- complete denture (D5520).
- Adjust partial denture – upper (D5421), lower (D5422): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit same date of service or within six months of the date of service of: a partial- resin base maxillary (D5211) mandibular (D5212) or partial denture- cast metal framework with resin denture bases maxillary (D5213) mandibular (D5214); same date of service or within six months of the date of service of a reline partial denture (chairside) maxillary (D5740) mandibular (D5741), reline partial denture (laboratory) maxillary (D5760) mandibular (D5761), and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair resin denture base (D5611 or D5612), repair cast framework (D5621 or D5622), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).
- Repair broken complete denture base (D5511 or D5512): A benefit once per arch, per date of service per provider; twice in a 12-month period per provider. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
- Replace missing or broken teeth - complete denture (each tooth) (D5520): A benefit up to a maximum of four, per arch, per date of service per provider; twice per arch, in a12- month period per provider.
- Repair resin denture base (D5611 or D5612): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider; for partial dentures only. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
- Repair cast framework (D5621 or D5622): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider.
- Repair or replace broken clasp (D5630): A benefit up to a maximum of three, per date of service per provider; twice per arch, in a 12- month period per provider.
- Replace broken teeth - per tooth (D5640): A benefit: up to a maximum of four, per arch, per date of service per provider; twice per arch, in a 12- month period per provider; for partial dentures only.
- Add tooth to existing partial denture (D5650): A benefit: for up to a maximum of three, per date of service per provider; once per tooth. Not a benefit for adding 3rd molars.
- Add clasp to existing partial denture (D5660): A benefit: for up to a maximum of three, per date of service per provider; twice per arch, in a 12-month period per provider.
- Reline complete denture (chairside) upper (D5730): a benefit once in a 12-month period; six months after the date of service for an immediate denture- maxillary (D5130)) or immediate overdenture-maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).

- Reline complete denture (chairside) lower (D5731): Each a benefit once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
- Reline partial denture (chairside) upper (D5740): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that required extractions, or 12 months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) maxillary (D5760).
- Reline partial denture (chairside) lower (D5741): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that required extractions, or 12 months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) mandibular (D5761).
- Reline complete denture (laboratory) upper (D5750): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) maxillary (D5730).
- Reline complete denture (laboratory) lower (D5751): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) mandibular (D5731).
- Reline upper partial denture (laboratory) (D5760): A benefit: once in a 12-month period; six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions. Not a benefit within 12 months of a reline maxillary partial denture (chairside) (D5740); for a maxillary partial denture- resin base (D5211).
- Reline lower partial denture (laboratory) (D5761): A benefit once in a 12-month period; six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions. Not a benefit within 12 months of a reline mandibular partial denture (chairside) (D5741); for a mandibular partial denture- resin base (D5212).
- Tissue conditioning, upper (D5850): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); or same date of service as a prosthesis that did not require extractions.
- Tissue conditioning, lower (D5851): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline

mandibular partial denture (laboratory) (D5761), or same date of service as a prosthesis that did not require extractions.

- Overdenture- maxillary (D5863): A benefit once in a five- year period.
- Overdenture-mandibular (D5865): A benefit once in a five- year period.

Benefits and Limitations for Maxillofacial Prosthetics

- Ocular prosthesis (D5916): Not a benefit on the same date of service as ocular prosthesis, interim (D5923).
- Ocular prosthesis, interim (D5923): Not a benefit on the same date of service with an ocular prosthesis (D5916).
- Obturator prosthesis, surgical (D5931): Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936)
- Obturator prosthesis, definitive (D5932): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, modification (D5933): A benefit twice in a 12 month period. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, interim (D5936): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).
- Feeding aid (D5951): A benefit for patients under the age of 18.
- Speech aid prosthesis, pediatric (D5952): A benefit for patients under the age of 18.
- Speech aid prosthesis, adult (D5953): A benefit for patients under the age of 18.
- D5955 Palatal lift prosthesis, definitive (D5955): Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).
- Palatal lift prosthesis, interim (D5958): Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
- Palatal lift prosthesis, modification (D5959): A benefit twice in a 12 month period. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).
- Speech aid prosthesis, modification (D5960): A benefit twice in a 12 month period. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).
- Fluoride gel carrier (D5986): A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

Benefits and Limitations for Implant Services

- Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by California Dental Network for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
    - cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
    - severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
    - skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
    - traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

- Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
- Single tooth implants are not a benefit of the California Dental Network Family Dental HMO.
- Surgical placement of implant body: endosteal implant (D6010): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
- Surgical placement: eposteal implant (D6040): See D6010
- Surgical placement: transosteal implant (D6050): See D6010
- Connecting bar - implant supported or abutment supported (D6055): See D6010
- Prefabricated abutment - includes modification and placement (D6056): See D6010
- Custom fabricated abutment - includes placement (D6057): See D6010
- Abutment supported porcelain/ceramic crown (D6058): See D6010
- Abutment supported porcelain fused to metal crown (high noble metal) (D6059): See D6010
- Abutment supported porcelain fused to metal crown (predominantly base metal) (D6060): See D6010
- Abutment supported porcelain fused to metal crown (noble metal) (D6061): See D6010
- Abutment supported cast metal crown (high noble metal) (D6062): See D6010
- Abutment supported cast metal crown (predominantly base metal) (D6063): See D6010
- Abutment supported cast metal crown (noble metal) (D6064): See D6010
- Implant supported porcelain/ceramic crown (D6065): See D6010
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) (D6066): See D6010
- Implant supported metal crown (titanium, titanium alloy, high noble metal) (D6067): See D6010
- Abutment supported retainer for porcelain/ceramic FPD (D6068): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal) (D6069): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) (D6070): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (noble metal) (D6071): See D6010
- Abutment supported retainer for cast metal FPD (high noble metal) (D6072): See D6010
- Abutment supported retainer for cast metal FPD (predominantly base metal) (D6073): See D6010
- Abutment supported retainer for cast metal FPD (noble metal) (D6074): See D6010
- Implant supported retainer for ceramic FPD (D6075): See D6010
- Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) (D6076): See D6010
- Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (D6091): See D6010
- Recement implant/abutment supported crown (D6092): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Recement implant/abutment supported fixed partial denture (D6093): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Abutment supported crown (titanium) (D6094): See D6010
- Repair implant abutment, by report (D6095): See D6010

Benefits and Limits for Fixed Prosthodontic Services:

- Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
- Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
- Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.
- Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.
- Pontic - cast predominantly base metal (D6211): A benefit: once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain fused to predominantly base metal (D6241): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain/ceramic (D6245): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - resin with predominantly base metal (D6251): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Crown - resin with predominantly base metal (D6721): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain/ceramic (D6740): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain fused to predominantly base metal (D6751): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 cast predominantly base metal (D6781): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 porcelain/ceramic (D6783): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - full cast predominantly base metal (D6791): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Recement bridge (D6930): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Fixed partial denture repair necessitated by restorative material failure (D6980): Not a benefit within 12 months of initial placement or previous repair, same provider.

Benefits and Limitations for Oral Surgery Services

- Extraction, coronal remnants - deciduous tooth (D7111): Not a benefit for asymptomatic teeth.
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140): Not a benefit to the same provider who performed the initial tooth extraction.

- Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated (D7210): A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
- Removal of impacted tooth - soft tissue (D7220): A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
- Removal of impacted tooth - partially bony (D7230): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
- Removal of impacted tooth - completely bony (D7240): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.
- Removal of impacted tooth - complete bony with unusual surgical complications (D7241): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
- Surgical removal of residual tooth roots (cutting procedure) (D7250): A benefit when the root is completely covered by alveolar bone. Not a benefit to the same provider who performed the initial tooth extraction.
- Oral Antral Fistula Closure (D7260): A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity. Not a benefit in conjunction with extraction procedures (D7111 – D7250).
- Primary closure of a sinus perforation (D7261): A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.
- Tooth reimplantation and/ or stabilization of accidentally evulsed or displaced tooth (D7270): A benefit once per arch regardless of the number of teeth involved, and for permanent anterior teeth only.
- Surgical access of an unerupted tooth (D7280): Not a benefit for patients age 21 and older or for 3rd molars.
- Placement of device to facilitate eruption of impacted tooth (D7283): A benefit only for patients in active orthodontic treatment. Not a benefit for patients age 21 and older; or for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Biopsy of oral tissue - hard (bone, tooth) (D7285): A benefit for the removal of the specimen only; once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Biopsy of oral tissue – soft (D7286): A benefit for the removal of the specimen only; up to a maximum of three per date of service. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Surgical repositioning of teeth (D7290): A benefit for permanent teeth only; once per arch; only for patients in active orthodontic treatment. Not a benefit for patients age 21 and older; or for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Transseptal fiberotomy/supra crestal fiberotomy, by report (D7291): A benefit once per arch; only for patients in active orthodontic treatment. Not a benefit for patients age 21 and older.
- Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7310): Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

- Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7320): A benefit regardless of the number of teeth or tooth spaces. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.
- Vestibuloplasty – ridge extension (secondary epithelialization) (D7340): A benefit once in a five year period per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch; on the same date of service with extractions (D7111-D7250) same arch.
- Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (D7350): A benefit once per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; on the same date of service with extractions (D7111- D7250) same arch.
- Excision of benign lesion, complicated (D7412): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Excision of malignant lesion, complicated (D7415): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Removal of lateral exostosis (maxilla or mandible) (D7471): A benefit once per quadrant; for the removal of buccal or facial exostosis only.
- Removal of Torus Palatinus (D7472): A benefit once in the patient's lifetime.
- Removal of torus mandibularis (D7473): A benefit once per quadrant.
- Surgical reduction of osseous tuberosity (D7485): A benefit once per quadrant.
- Incision and drainage of abscess - intraoral soft tissue (D7510): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces). (D7511): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue (D7530): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Removal of reaction producing foreign bodies, musculoskeletal system (D7540): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Partial ostectomy /sequestrectomy for removal of non-vital bone (D7550): A benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a benefit within 30 days of an associated extraction (D7111-D7250).
- Maxillary sinusotomy for removal of tooth fragment or foreign body (D7560): Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7680): A benefit for the treatment of simple fractures.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7780): A benefit for the treatment of compound fractures.
- Occlusal orthotic device, by report (D7880): A benefit for diagnosed TMJ dysfunction. Not a benefit for the treatment of bruxism.
- Unspecified TMD therapy, by report (D7899): Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis
- Suture of recent small wounds up to 5 cm (D7910): Not a benefit for the closure of surgical incisions.
- Complicated suture – up to 5 cm (D7911): Not a benefit for the closure of surgical incisions.
- Complicated suture – greater than 5 cm (D7912): Not a benefit for the closure of surgical incisions.

- Skin graft (identify defect covered, location and type of graft) (D7920): Not a benefit for periodontal grafting.
- Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report (D7950): Not a benefit for periodontal grafting.
- Sinus augmentation with bone or bone substitutes via a lateral open approach (D7951): A benefit only for patients with authorized implant services.
- Sinus augmentation with bone or bone substitute via a vertical approach (D7952): A benefit only for patients with authorized implant services.
- Repair of maxillofacial soft and/or hard tissue defect (D7955): Not a benefit for periodontal grafting.
- Frenulectomy – also known as frenectomy or frenotomy – separate procedure (D7960): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Frenuloplasty (D7963): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Excision of hyperplastic tissue - per arch (D7970): A benefit once per arch per date of service. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
- Surgical reduction of fibrous tuberosity (D7972): A benefit once per quadrant per date of service.
- Appliance removal (not by dentist who placed appliance), includes removal of archbar (D7997): A benefit once per arch per date of service; for the removal of appliances related to surgical procedures only. Not a benefit for the removal of orthodontic appliances and space maintainers.

Benefits and Limitations for Orthodontic Services

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:
    - cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - a crossbite of individual anterior teeth causing destruction of soft tissue,
    - an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    - a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
- Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion (D8080): A benefit for handicapping malocclusion, cleft palate and facial growth management cases; for patients

under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per patient per phase of treatment.

- Removable appliance therapy (D8210): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Fixed appliance therapy (D8220): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Pre-orthodontic treatment visit (D8660): A benefit prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three months; for patients under the age of 21; for a maximum of six.
- Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion (D8670): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter.
- The maximum quantity of monthly treatment visits for the following phases are:
- Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Cleft Palate:
        - Primary dentition– up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Facial Growth Management:
        - Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
- Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (D8680): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per arch for each authorized phase of orthodontic treatment.
- Repair of orthodontic appliance (D8691): A benefit for patients under the age of 21; once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
- Replacement of lost or broken retainer (D8692): A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention (D8680).
- Rebonding or recementing: and/or repair, as required, of fixed retainers (D8693): A benefit for patients under the age of 21; once per provider.

Benefits and Limitations for Adjunctive Services

- Palliative (emergency) treatment of dental pain - minor procedure (D9110): A benefit once per date of service per provider regardless of the number of teeth and/or areas treated. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Fixed partial denture sectioning (D9120): A benefit when at least one of the abutment teeth is to be retained.
- Local anesthesia not in conjunction with outpatient surgical procedures (D9210): A benefit once per date of service per provider, only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Deep sedation/general anesthesia - each 15 minute increment (D9223): Not a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9243 or D9239) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Analgesia nitrous oxide (D9230): A benefit for uncooperative patients under the age of 13, or for patients age 13, or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9243 or D9239) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - first 15 minutes (D9239): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment (D9243): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Non-intravenous conscious sedation (D9248): A benefit for uncooperative patients under the age of 13, or for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration; once per date of service. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9243 or D9239); when all associated procedures on the same date of service by the same provider are denied.
- House/Extended care facility call (D9410): A benefit once per patient per date of service; only in conjunction with procedures that are payable.
- Hospital or ambulatory surgical center call (D9420): A benefit for each hour or fraction thereof as documented on the operative report. Not a benefit: for an assistant surgeon; for time spent compiling the patient history, writing reports or for post- operative or follow up visits.
- Office visit for observation (during regularly scheduled hours) - no other services performed (D9430): A benefit once per date of service per provider. Not a benefit when procedures other than necessary radiographs and/or photographs are provided on the same date of service; for visits to patients residing in a house/ extended care facility.

- Office visit - after regularly scheduled hours (D9440): A benefit once per date of service per provider; only with treatment that is a benefit.
- Therapeutic parenteral drug, single administration (D9610): A benefit for up to a maximum of four injections per date of service. Not a benefit for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9243 or D9239) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Application of desensitizing medicament (D9910): A benefit once in a 12-month period per provider; for permanent teeth only. Not a benefit when used as a base, liner or adhesive under a restoration; the same date of service as fluoride (D1206 and D1208).
- Treatment of complications (post-surgical) - unusual circumstances, by report (D9930): A benefit once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; for the removal of bony fragments within 30 days of the date of service of an extraction. Not a benefit for the removal of bony fragments on the same date of service as an extraction; for routine post- operative visits.
- Occlusion analysis – mounted case (D9950): A benefit once in a 12-month period; for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition. Not a benefit for bruxism only.
- Occlusal adjustment – limited (D9951): A benefit once in a 12-month period per quadrant per provider; for patients age 13 or older; for natural teeth only. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.
- Occlusal adjustment – complete (D9952): A benefit once in a 12-month period following occlusion analysis- mounted case (D9950); for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition.

XVIII. BENEFITS, EXCLUSIONS, AND LIMITATIONS FOR ADULT MEMBERS (AGES 19 AND ABOVE)

California Dental Network Covered California Family Dental HMO Benefits are set forth in the attached list of covered procedures and are subject to the applicable member cost (copayment) in the list, when provided by a CDN Participating Dental Participating Dentist and subject to the Exclusions and Limitations contained herein. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable.

EXCLUSIONS

- Treatment of fractures or dislocations; congenital malformations; malignancies, cysts, or neoplasms; or Temporomandibular Joint Syndrome (TMJ).
- Extractions or x-rays for orthodontic purposes.
- Prescription Drugs and over the counter medicines.
- Any services involving implants or experimental procedures.
- Any procedures performed for cosmetic, elective or aesthetic purposes
- Any procedure to replace or stabilize tooth structure lost by attrition, abrasion, erosion or grinding.
- Any procedure not specifically listed as a covered Benefit.
- Services provided outside the CDN Participating General Dentist's office that the Member selected, or was assigned, to receive covered services, unless expressly authorized by CDN.
- Services, which in the opinion of the attending CDN dentist, cannot be performed in the dental office due to the general health and/or physical or behavioral limitations of the Member.

- Services for injuries or conditions, which were caused by acts of war, or are covered under Worker's Compensation or Employer's Liability Laws.
- Services which in the opinion of the attending CDN dentist are not necessary for the Member's dental health or which have a poor prognosis.
- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Crowns are limited to five per arch per year.

XVIII. RENEWAL, CHANGES, AND TERMINATION

How Does CDN Coverage Renew?

Your coverage will be automatically renewed at the same terms and conditions unless CDN notifies you in writing at least 30 days before the end of your coverage term describing any changes in the premium, coverage or other terms or conditions of your coverage.

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after sixty (60) calendar days' notice to the Subscriber's address of record with CDN.

When Will My CDN Membership End? (Termination of Benefits and Coverage)
If your employer or group does not pay the premium, CDN will send a notice to your employer or group saying that the premium is overdue.

If premiums are not paid according to the agreement, termination will be effective on midnight 30 days after the last day of the month for which premiums were last received, subject to compliance with notice requirements accepted by California Dental Network. This is equivalent to a minimum of a 30-day grace period. The termination date of your coverage is the first day you are not covered with CDN (for example, if your termination date is July 1, 2015, your last minute of coverage was at 11:59 p.m. on June 30, 2015).

You may request a review by the Director of the Department of Managed Health Care if you believe that this Agreement has been or will be improperly cancelled, rescinded or not renewed. you may contact the Department of Managed Health Care at its toll-free number, 1 (888) HMO-2219 (1-888-466-2219) or TDD number for the deaf or hard of hearing, toll-free, at 1 (877) 688-9891, or online at www.hmohelp.ca.gov.

Your membership with CDN will terminate if you:

- No Longer Meet Eligibility Requirements: Your employer or group no longer subscribes to California Dental Network for dental coverage. If this happens, you will receive notice through your employer or group administrator at least 30 days before the change takes effect. Coverage for your Dependents will also end. You no longer meet age or other eligibility requirements for coverage under this product as required by CDN or Covered California. Your CDN Plan coverage may also end if your job ends or you no longer work enough hours to be on your employer's plan. In this case coverage for your Dependents also ends. You no longer live or work in CDN's Service Area for this product.
- Fraud or Misrepresentation: you commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of your coverage with CDN, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed.

If you claim that we ended the Member's right to receive Covered Services because of the Member's health status or requirements for health care services, you may request a review. To request a review call the Department of Managed Health Care by calling toll-free at 1 (800) 400-0815.

Either CDN or the Subscriber Group may cancel this Group Subscriber Agreement if any party breaches the terms or conditions of this Subscriber Agreement. Health plan termination shall be effective the last day of the month in which the termination of this Subscriber Agreement occurs.

Should this Group Subscriber Agreement be terminated because the Group hasn't remitted to CDN any fees owed, and then pays CDN by the date the next payment is due, this Group Subscriber Agreement will be automatically reinstated as if never terminated.

This Group Subscriber Agreement will be terminated for Group's failure to remit the Prepayment Fees, or provide eligibility list as required, in which case the Group will be given thirty (30) days written notice. The Group will have thirty (30) days to remit the appropriate Prepayment Fees, when due, from receipt of notice, in which to remedy the default.

Both parties agree that CDN shall have the absolute right to terminate this Group Subscriber Agreement should Group fail to remit the Prepayment Fees, within the 30-day period after notice. In the event of cancellation by either the Plan (except in the case of fraud or deception in the use of services or facilities of the Plan or knowingly permitting such fraud or deception by another) or the other party, the Plan shall within 30 days return to the other part the pro rate portion of the money paid to Plan which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the Plan.

This Group Subscriber Agreement will be terminated should a Subscriber engage in fraudulent conduct with respect to this Group Subscriber Agreement.

If you believe your Membership has been cancelled or not renewed because of health status or requirements for services, you may request a review by the Department of Managed Health Care. A reinstatement pursuant to this section shall be retroactive to the time of cancellation or failure to renew and the Plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

XIX. INDIVIDUAL CONTINUATION OF DENTAL COVERAGE (COBRA, CAL-COBRA)

A. COBRA

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA), toll-free, at 1-866-444-3272.

- COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.
- COBRA may allow you and your Dependents to keep CDN coverage for up to 18 or 36 months, depending on the qualifying event and other circumstances. If you are no longer eligible for COBRA after 18 months, you may be able to keep your Benefits through Cal-COBRA. See below.
- Each qualified person may independently elect/enroll in COBRA coverage. A parent or legal guardian may elect COBRA for a minor child.
- With COBRA, You have the same Benefits as current Members with CDN coverage.
- You have to pay all of the monthly premium.

Important deadlines for electing/enrolling in COBRA with CDN:

It is important to meet the following deadlines. If you do not, you lose your right to COBRA coverage.

1. Notification of qualifying event:

   Employers must notify CDN within 30 days after the following qualifying events:

   - The employee's job ends
   - The employee’s hours of employment are reduced
   - The employee becomes eligible to receive Medicare Benefits
   - The employee dies

   You or your Dependent must notify CDN in writing within 60 days after any of the following qualifying events:

   - The employee divorces or legally separates
   - A child or other Dependent no longer qualifies as a Dependent under plan rules

2. Election notice: Generally, you must be sent an election notice not later than 14 days after your Employer receives notice that a qualifying event has occurred.

3. Election period: You have 60 days to notify your employer in writing that you want to elect/enroll in COBRA coverage. The 60 days starts on the later of the following two dates:
   - The date you receive the election notice.
   - The date your coverage ended.

4. Premium payment: you must pay the premiums for your COBRA coverage as per instructions provided by your Employer. CDN must receive your first premium within 45 days after you enroll in COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day you signed up for COBRA. You must then pay a monthly premium as instructed by your Employer and/or CDN as long as you stay on COBRA.

If your COBRA is ending, you may be able to elect/enroll in Cal-COBRA:
When your 18 months of COBRA ends, you may be able to keep CDN coverage for up to 18 more months under Cal-COBRA. If you were on COBRA for 36 months, you cannot get Cal-COBRA for any additional period of time.

Your employer should send you an enrollment form. You must fill out the enrollment form, and return it to your employer as instructed, and pay your premium no more than 30 days after You receive the enrollment form.

You will lose COBRA if:
- You do not pay your premiums on time.
- You move outside the CDN Service Area.
- Your former employer no longer offers any health plan.
- You become eligible for Medicare.
- You sign up for another health plan.
- You commit fraud, which means that you intentionally deceive CDN or you misrepresent yourself or allow someone else to do so in order to get health care services.

B. Cal-COBRA
Cal-COBRA is a California law that applies to Employers who have between 2 and 19 employees in their group health plan.
- Cal-COBRA may allow you, your Dependents, and former Dependents to keep CDN coverage for up to 36 months.
- You have the same Benefits as current Members with CDN coverage.
- You have to pay all of the monthly premium.

Important deadlines for electing/enrolling in Cal-COBRA with CDN:
It is important to meet the following deadlines. If you do not, you lose your right to Cal-COBRA coverage.
1. Notification of qualifying event: Employers must notify CDN within 30 days after the following qualifying events:
   - The employee's job ends
   - The employee’s hours of employment are reduced

You or your Dependent must notify your employer and CDN in writing within 60 days after any of the following qualifying events:

- The employee dies
- The employee divorces or legally separates
- A child or other Dependent no longer qualifies as a Dependent under plan rules
- The employee becomes eligible to receive Medicare Benefits

2. Election notice: Generally, You must be sent an election notice not later than 14 days after your employer receives notice that a qualifying event has occurred.

3. Election period: You have 60 days to notify your employer and/or CDN in writing that you want to elect/enroll in Cal- COBRA continuation coverage. The 60 days starts on the later of the following two dates:
   - The date you receive the election notice.
   - The date your coverage ended.

4. Premium payment: You must pay the premiums for your Cal-COBRA coverage as instructed by your employer. CDN must receive your first premium from your employer within 45 days after you enroll in Cal-COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day You signed up for Cal- COBRA. You must then pay a monthly premium as instructed by your employer as long as you stay on Cal-COBRA.

If your former employer stops offering CDN when you are on Cal-COBRA:

- You can elect/enroll in Cal-COBRA with the new health plan offered by your employer.
- You must enroll and pay your first premium as instructed by your employer with the new health plan no more than 30 days after You receive notice that CDN is no longer being offered. If you do not meet this deadline, your Cal-COBRA Benefits end.

You will lose Cal-COBRA if:

- You do not pay your premiums on time.
- You move outside the CDN Service Area.
- Your former employer no longer offers any health plan.
- You sign up for or become eligible for Medicare.
- You sign up for another health plan. (However, if your new plan has a waiting period for pre-existing conditions and you have not used up all of your Cal-COBRA, You can keep your Cal-COBRA until the waiting period is over.)
- You commit fraud, which means that you intentionally deceive CDN or you misrepresent yourself or allow someone else to do so in order to get health care services.

XX. TIMELY ACCESS TO CARE & INTERPRETER SERVICES

CDN is required to provide or arrange for the provision of covered dental care services in a timely manner appropriate for the nature of the enrollee's condition, consistent with good professional practice. CDN ensures that enrollees are able to access clinically appropriate care in a timely manner. Urgent appointments within the CDN contracted provider network are available within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental

practice. Non-urgent (routine) appointments are available within 36 business days of the request for appointment. Preventive dental care appointments are available within 40 business days of the request for appointment.
Interpreter services (as required by Section 1300.67.04 of Title 28) will be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To arrange for interpreter services at your dental appointment, please contact the CDN member services department.

XXI. COMPLAINTS, DISPUTES AND GRIEVANCES

Any complaint you may have should initially be brought to the attention of your Participating Dentist. If it is not resolved to your satisfaction, you are encouraged to contact CDN. Any information, inquiries, complaints or disputes regarding any problems that are encountered while obtaining services should be made to CDN. Complaint forms as well as a copy of CDN's Grievance Procedures are available upon request. Member complaints or grievances can be made in person, at any Participating Dentist's office or by obtaining a Grievance Form from CDN by writing, faxing or calling CDN as follows, or by visiting the website at www.caldental.net:

California Dental Network, Inc
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
Phone (949) 830-1600: Toll-Free 1-855-425-4164
Fax (949) 830-1655

Completed Grievance Forms must be mailed to CDN at the address listed above.

Members, or their representatives, with limited English proficiency or with visual or other communicative impairment can contact the Plan for assistance at the numbers shown above.
CDN agrees to duly investigate and endeavor to resolve any and all complaints received. Member complaints will be acknowledged in writing within five calendar days of receipt by the Plan. Members will receive a written response within 30 days as to the disposition of the complaint, or measures taken to correct any problems. Such written response to a grievance will provide subscribers and enrollees with a clear and concise explanation of the reasons for the Plan's response. For grievances involving the delay, denial, or modification of health care services, the Plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its contracting Participating Dentists, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the decision shall clearly specify the provisions in the contract that exclude that coverage. Members who are not satisfied with the Plan's response to the Grievance have the right to file a complaint with the California Department of Managed Healthcare.

If the complaint or grievance requires an immediate review for an urgent or emergency quality of care issue, as defined in the Emergency Referral section of the Quality Assurance Program, including severe pain, as determined by the Plan's Dental Director, the time period for Plan action as set forth above shall not apply. In such cases, the complaint or grievance will be handled by the Plan within three business days, and the Plan Member will be notified of the result immediately thereafter. Members and the Department of Managed

Health Care will be provided with the status as quickly as possible and, in the case of written statement, within three days of receipt of the grievance.

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 1-949-830-1600 or toll-free 1-855-425-4164 and use your Health Plan's grievance process before contacting the Department. For the hearing and speech impaired, dial 711 to call with the Telecommunications Relay Service. 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.**

The department may require enrollees and subscribers to participate in a plan's grievance process for up to 30 days before pursuing a grievance through the department. However, the department may not impose this waiting period for expedited review cases covered by subdivision (b) of Section 1368.01 of the California Health & Safety Code or in any other case where the department determines that an earlier review is warranted.

Health Plan Linguistic and Cultural Policy Regarding Grievances
The Plan's grievance system ensures that all Members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. When requested by a Member and/or his or her representative, the Plan will assist Members with limited English proficiency to obtain translation or interpretation of the Plan's grievance procedures, forms, and responses to grievances. The Plan will assist Members with visual or other communicative impairments in locating telephone relay systems and other devices and/or services that aid disabled individuals to communicate, so that the Member may participate in the grievance system.

Members who file a grievance against the Plan will not be discriminated or retaliated against in any way.

XXII. BINDING ARBITRATION

Any complaint, dispute or grievance arising between a Member and CDN, not resolved by CDN's grievance system and involving the Agreement or any of its terms and conditions, its breach or non-performance, or involving any claim of dental malpractice, shall be settled by arbitration pursuant to the rules and regulations then in force and effect of the American Arbitration Association.
The arbitration shall take place in Orange County, California and judgment upon any award rendered by the arbitrator may be duly entered in any court in the State of California having jurisdiction thereof.
The prevailing party shall be entitled to court costs and reasonable attorney's fees. CDN will assume all or part of the Member's share of the fees and expenses of the neutral arbitrator

XXIII. DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records (including any personal or privileged information, medical records, patient charts, etc.) shall remain confidential. Such confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.

Such information may also be made available to the Department of Managed Health Care, the Dental Board and CDN's legal representatives or other agencies as required by law.
A Plan Member or the non-covered parent of a covered child may request access to or a copy of personal information and medical records. Written consent for release of patient information and records is required to be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to such a request within 30 days after receipt of the appropriate executed forms and fees.

CDN's confidentiality policy is available for review to all plan members upon request.

A Plan Member may request to have an addendum of 250 or fewer words added to his or her medical records, in compliance with state law. This request should be made directly to the Participating Dentist who has custody of the records. Should the Participating Dentist deny Member the request to add an addendum, the Member should contact CDN for assistance.

A STATEMENT DESCRIBING CDN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

XXIV. ADDITIONAL INFORMATION

If the Participating Dentist fails to comply with the terms and conditions of this Evidence of Coverage and Disclosure Form, the Member should advise CDN of the Participating Dentist's breach of the Agreement.

CDN has a Public Policy Committee that reviews and approves all actions of the Quality Assurance Committee. This Committee reports to the Board of Directors. The Public Policy committee is composed of at least 51% Members and health care Participating Dentists. Members who would like to participate on this Committee should submit their request to CDN's President.

XXV. ORGAN AND TISSUE DONATION

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

XXVI. GENERAL PROVISIONS

CDN is subject to the requirements of the Act and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provisions required to be in this Agreement by either of the above shall bind CDN whether or not provided in this Agreement. In the event that the Act or Regulations thereunder set forth any

requirement that is not included herein or is contrary to this Agreement, it shall supersede the applicable provisions of this Agreement and shall be binding unto the parties hereto.

Nothing contained herein shall preclude CDN from changing the location of any of its dental offices, as long as it retains a sufficient Participating Dentist network to provide dental services to Group.

In the event any of CDN's Participating Dentists should terminate their relationship with CDN, breach their Subscriber Agreement with CDN, or be unable to render dental services hereunder, and Subscriber and or its Subscribers would be adversely or materially affected, CDN will give Subscriber written notice thereof.

Upon termination of a Participating Dentist Contract, CDN shall be liable for covered services rendered by such Participating Dentist (other than for Copayments as defined in subdivision (g) of Section 1345 of the Act) to Members who retain eligibility under this Agreement or by operation of law under the care of such Participating Dentist at the time of such termination until the services being rendered to the Members by such Participating Dentist are completed, unless CDN makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Dentist.

If any provision of this Agreement is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Agreement, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Agreement.

This Agreement is non-assignable by either party without the prior written consent of the other party. CDN may, in its sole discretion, delegate administrative functions to other entities.

This Agreement constitutes the entire Agreement of the parties. This Agreement may only be modified in writing and executed by the parties.

Pursuant to Section 1365(b) of the Act, any Subscriber who alleges his enrollment has been cancelled or not renewed because of his health status or requirement for services may request review by the California Department of Managed Health Care. A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation or failure to renew and the Plan shall be liable for the expenses incurred by the Subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

It is expressly understood that the relationship between Members and Participating Dentists shall be subject to the rules, limitations and privileges incident to the doctor-patient relationship. CDN shall be solely responsible to the Member for arranging dental advice and treatment, including the right to object to treating any Member who continually fails to follow a prescribed course of treatment, who uses the relationship for illegal purposes, or who attempts to make onerous the doctor-patient relationship.

XXVII. NON- DISCRIMINATION NOTICE

California Dental Network complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. California Dental Network does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

California Dental Network:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call customer service at 1-855-425-4164.
If you believe that California Dental Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Ugonna Onyekwu
Civil Rights Coordinator Compliance Department
465 Medford Street Boston, MA 02159
Fax: 617-886-1390 Phone: 617-886-1683
Email: FairTreatment@greatdentalplans.com TTY: 711
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

XXVIII. INDEPENDENT MEDICAL REVIEW

External independent review is available to members for review of denials of experimental therapies where such therapies might be indicated for treatment of a life threatening condition or seriously debilitating illness or for denials based on service not being medically necessary by contacting Member Services within five business days of the denial. The request for an independent medical review will be reviewed by the Dental Director or, if necessary, referred to the Quality Assurance Committee. Timeframes for considering independent medical review requests will be the same as for grievance processing. Members have the right to file information in support of the request for independent medical review.

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 (1-855-425-4164) 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.

Member Copayment Schedule 2020
California Dental Network Family Dental HMO

Family Dental HMO	Children (up to Age 19)	Adult (Age 19 and older)
Deductibles	None	None
Out of Pocket Maximums	Individual Child- $350	Not Applicable
	Two or more Children in a family - $700	Not Applicable
Office Copay	No Charge	No Charge
Waiting Period	None	None
Annual Benefit Limit	None	None

		Member Copayment	
Code	**Description**	**Child (up to Age 19)**	**Adult (Age 19 and older)**
D0120	periodic oral evaluation	No Charge	No Charge
D0140	limited oral evaluation	No Charge	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge	Not Covered
D0150	comprehensive oral evaluation	No Charge	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge	No Charge
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	No Charge	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge	No Charge
D0180	Comprehensive periodontal evaluation	No Charge	No Charge
D0190	screening of a patient	Not Covered	No Charge
D0191	assessment of a patient	Not Covered	No Charge
D0210	intraoral - complete series (including bitewings) - limited to 1 series every 36 months	No Charge	No Charge
D0220	intraoral - periapical first film	No Charge	No Charge
D0230	intraoral - periapical each additional film	No Charge	No Charge
D0240	intraoral - occlusal film	No Charge	No Charge
D0250	Extraoral - first film	No Charge	No Charge
D0251	Extra-oral posterior dental radiographic image	No Charge	Not Covered
D0270	bitewing - single film	No Charge	No Charge
D0272	bitewings - two films	No Charge	No Charge
D0273	Bitewings - three films	No Charge	No Charge
D0274	bitewings - four films - limited to 1 series every 6 months	No Charge	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge	No Charge
D0310	Sialography	No Charge	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge	No Charge
D0322	Tomographic survey	No Charge	No Charge
D0330	panoramic film	No Charge	No Charge
D0340	Cephalometric radiographic image	No Charge	No Charge
D0350	photograph 1st	No Charge	No Charge
D0351	3D photographic image	No Charge	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	No Charge
D0460	pulp vitality tests	No Charge	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge	No Charge
D0502	Other oral pathology procedures, by report	No Charge	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge	No Charge

Member Copayment Schedule 2020
California Dental Network Family Dental HMO

D0603	caries risk assessment and documentation, with a finding of high risk	No Charge	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge	Not Covered
D1110	prophylaxis - adult	No Charge	No Charge
D1120	prophylaxis - child	No Charge	Not Covered
D1206	topical fluoride varnish	No Charge	No Charge
D1208	topical application of fluoride	No Charge	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge	No Charge
D1330	oral hygiene instructions	No Charge	No Charge
D1351	sealant - per tooth	No Charge	Not Covered
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge	Not Covered
D1353	Sealant repair – per tooth	No Charge	Not Covered
D1354	Interim caries arresting medicament application—per tooth	No Charge	No Charge
D1510	space maintainer - fixed - unilateral	No Charge	Not Covered
D1516	space maintainer - fixed – bilateral, maxillary	No Charge	Not Covered
D1517	space maintainer - fixed – bilateral, mandibular	No Charge	Not Covered
D1520	Space maintainer-removable – unilateral	No Charge	Not Covered
D1526	space maintainer - removable – bilateral, maxillary	No Charge	Not Covered
D1527	space maintainer - removable – bilateral, mandibular	No Charge	Not Covered
D1550	Re-cementation of space maintainer	No Charge	Not Covered
D1555	Removal of fixed space maintainer	No Charge	Not Covered
D1575	Distal shoe space maintainer – fixed – unilateral	No Charge	Not Covered
D2140	amalgam - one surface permanent or primary	$25	$25
D2150	amalgam - two surfaces permanent or primary	$30	$30
D2160	amalgam - three surfaces permanent or primary	$40	$40
D2161	amalgam - four or more surfaces permanent or primary	$45	$45
D2330	resin-based composite - one surface, anterior	$30	$30
D2331	resin-based composite - two surfaces, anterior	$45	$45
D2332	resin-based composite - three surfaces, anterior	$55	$55
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	$60
D2390	Resin based composite crown, anterior	$50	$50
D2391	Resin based composite - one surface, posterior	$30	$30
D2392	Resin based composite - two surfaces, posterior	$40	$40
D2393	Resin based composite - three surfaces, posterior	$50	$50
D2394	Resin based composite - four or more surfaces, posterior	$70	$70
D2542	onlay - metallic-two surfaces	Not Covered	$185
D2543	onlay - metallic-three surfaces	Not Covered	$200
D2544	onlay - metallic-four or more surfaces	Not Covered	$215
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	$250
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	$275
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	$300
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$160
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$180
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$200
D2710	crown - resin-based composite laboratory	$140	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190	$200
D2720	Crown - resin with high noble metal	Not Covered	$300

Member Copayment Schedule 2020
California Dental Network Family Dental HMO

D2721	Crown - resin with predominantly base metal	$300	$300
D2722	Crown - resin with noble metal	Not Covered	$300
D2740	crown - porcelain/ceramic substrate	$300	$300
D2750	crown - porcelain fused to high noble metal	Not Covered	$300
D2751	crown - porcelain fused to predominantly base metal	$300	$300
D2752	crown - porcelain fused to noble metal	Not Covered	$300
D2780	Crown - 3/4 cast high noble metal	Not Covered	$300
D2781	crown - 3/4 cast predominantly base metal	$300	$300
D2782	Crown - 3/4 cast noble metal	Not Covered	$300
D2783	Crown – 3/4 porcelain/ceramic	$310	$310
D2790	crown - full cast high noble metal	Not Covered	$300
D2791	crown - full cast predominantly base metal	$300	$300
D2792	crown - full cast noble metal	Not Covered	$300
D2910	Recement inlay, onlay or partial coverage restoration	$25	$25
D2915	Recement cast or prefabricated post and core	$25	$25
D2920	Recement crown	$25	$15
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	Not Covered
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not Covered
D2930	prefabricated stainless steel crown - primary tooth	$65	Not Covered
D2931	prefabricated stainless steel crown - permanent tooth	$75	$75
D2932	Prefabricated resin crown	$75	Not Covered
D2933	Prefabricated stainless steel crown with resin window	$80	Not Covered
D2940	protective restoration	$25	$20
D2941	Interim therapeutic restoration – primary dentition	$30	Not Covered
D2949	Restorative foundation for an indirect restoration	$45	Not Covered
D2950	Core buildup, including any pins	$20	$20
D2951	pin retention - per tooth, in addition to restoration	$25	$20
D2952	post and core in addition to crown, indirectly fabricated	$100	$60
D2953	Each additional indirectly fabricated post, same tooth	$30	$30
D2954	prefabricated post and core in addition to crown	$90	$60
D2955	Post removal	$60	Not Covered
D2957	Each additional prefabricated post - same tooth	$35	$35
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	Not Covered
D2980	crown repair, by report	$50	$50
D2999	Unspecified restorative procedure, by report	$40	Not Covered
D3110	pulp cap - direct (excluding final restoration)	$20	$20
D3120	Pulp cap (indirect) excluding final restoration	$25	$25
D3220	therapeutic pulpotomy (excluding final restoration)	$40	$35
D3221	Pulpal debridement, primary and permanent teeth	$40	$50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	Not Covered
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55	Not Covered
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55	Not Covered
D3310	root canal therapy, anterior tooth (excluding final restoration)	$195	$200
D3320	root canal therapy, bicuspid tooth (excluding final restoration)	$235	$235
D3330	root canal therapy, molar (excluding final restoration)	$300	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	$85

Member Copayment Schedule 2020
California Dental Network Family Dental HMO

D3333	Internal root repair of perforation defects	$80	Not Covered
D3346	retreatment of previous root canal therapy - anterior	$240	$245
D3347	retreatment of previous root canal therapy - bicuspid	$295	$295
D3348	retreatment of previous root canal therapy - molar	$365	$365
D3351	apexification/recalcification – initial visit	$85	Not Covered
D3352	apexification/recalcification - interim	$45	Not Covered
D3410	apicoectomy/periradicular surgery - anterior	$240	$240
D3421	apicoectomy/periradicular surgery - bicuspid (first root)	$250	$250
D3425	apicoectomy/periradicular surgery - molar (first root)	$275	$275
D3426	Apioectomy / periradicular surgery - molar, each additional root	$110	$110
D3427	Periradicular surgery without apicoectomy	$160	$160
D3430	retrograde filling - per root	$90	$90
D3450	root amputation - per root	Not Covered	$110
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	Not Covered
D3920	Hemisection (including any root removal; not including root canal therapy)	Not Covered	$120
D3950	Canal preparation and fitting of preformed dowel or post	Not Covered	$60
D3999	Unspecified endodontic procedure, by report	$100	Not Covered
D4210	gingivectomy or gingivoplasty - – four or more contiguous teeth or tooth bounded spaces per quadrant	$150	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50
D4240	Gingival flap procedure including root planing four or more teeth per quadrant	Not Covered	$135
D4241	Gingival flap procedure including root planing one to three teeth per quadrant	Not Covered	$70
D4249	Clinical crown lengthening – hard tissue	$165	$200
D4260	Osseous – muco - gingival surgery per quadrant	$265	$265
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	$140	$140
D4263	Bone replacement graft - first site in quadrant	Not Covered	$105
D4264	Bone replacement graft - each additional site in quadrant	Not Covered	$75
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	Not Covered
D4266	Guided tissue regeneration - resorbable barrier - per site	Not Covered	$145
D4267	Guided tissue regeneration - non-resorbable barrier - per site (includes membrane removal)	Not Covered	$175
D4270	Pedicle soft tissue graft procedure	Not Covered	$155
D4273	Subepithelial connective tissue graft procedure - per tooth	Not Covered	$220
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	Not Covered	$190
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$185
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$175
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$55	$55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$30	$25
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$220	$220
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$40	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	$10
D4910	Periodontal maintenance	$30	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15	Not Covered
D4999	Unspecified periodontal procedure, by report	$350	Not Covered
D5110	complete denture - maxillary	$300	$400
D5120	complete denture - mandibular	$300	$400

Member Copayment Schedule 2020
California Dental Network Family Dental HMO

D5130	immediate denture - maxillary	$300	$400
D5140	immediate denture - mandibular	$300	$400
D5211	maxillary partial denture - resin based with conventional clasps, rests and teeth	$300	$325
D5212	mandibular partial denture - resin based with conventional clasps, rests and teeth	$300	$325
D5213	maxillary partial denture - cast metal resin based with conventional clasps, rests and teeth	$335	$375
D5214	mandibular partial denture - cast metal resin based with conventional clasps, rests and teeth	$335	$375
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$275	Not Covered
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$275	Not Covered
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330	Not Covered
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330	Not Covered
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Not Covered	$250
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	Not Covered	$250
D5410	adjust complete denture - maxillary	$20	$20
D5411	adjust complete denture – mandibular	$20	$20
D5421	adjust partial denture – maxillary	$20	$20
D5422	adjust partial denture – mandibular	$20	$20
D5511	repair broken complete denture base-mandibular	$40	$30
D5512	repair broken complete denture base-maxillary	$40	$30
D5520	replace missing or broken teeth - complete denture (each tooth)	$40	$30
D5611	repair resin denture base-mandibular	$40	$30
D5612	repair resin denture base-maxillary	$40	$30
D5621	repair cast framework-mandibular	$40	$35
D5622	repair cast framework-maxillary	$40	$35
D5630	repair or replace broken clasp	$50	$30
D5640	replace broken teeth - per tooth	$35	$30
D5650	add tooth to existing partial denture	$35	$35
D5660	add clasp to existing partial denture	$60	$45
D5670	Replace all teeth and acrylic on cast framework - maxillary	Not Covered	$195
D5671	Replace all teeth and acrylic on cast framework - mandibular	Not Covered	$195
D5710	Rebase complete maxillary denture	Not Covered	$155
D5711	Rebase complete mandibular denture	Not Covered	$155
D5720	Rebase maxillary partial denture	Not Covered	$150
D5721	Rebase mandibular partial denture	Not Covered	$150
D5730	reline complete maxillary denture (chairside)	$60	$80
D5731	reline complete mandibular denture (chairside)	$60	$80
D5740	reline maxillary partial denture (chairside)	$60	$75
D5741	reline mandibular partial denture (chairside)	$60	$75
D5750	reline complete maxillary denture (laboratory)	$90	$120
D5751	reline complete mandibular denture (laboratory)	$90	$120
D5760	reline maxillary partial denture (laboratory)	$80	$110
D5761	reline mandibular partial denture (laboratory)	$80	$110
D5850	tissue conditioning, maxillary	$30	$35
D5851	tissue conditioning, mandibular	$30	$35
D5862	Precision attachment, by report	$90	Not Covered

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D5876	Add metal substructure to acrylic full denture (per arch)	Not Covered	$30
D5863	Overdenture – Complete Maxillary	$300	Not Covered
D5864	Overdenture – partial maxillary	$300	Not Covered
D5865	Overdenture – Complete Mandibular	$300	Not Covered
D5866	Overdenture – partial mandibular	$300	Not Covered
D5899	Unspecified removable prosthodontic procedure, by report	$350	Not Covered
D5911	Facial moulage (sectional)	$285	Not Covered
D5912	Facial moulage (complete)	$350	Not Covered
D5913	Nasal prosthesis	$350	Not Covered
D5914	Auricular prosthesis	$350	Not Covered
D5915	Orbital prosthesis	$350	Not Covered
D5916	Ocular prosthesis	$350	Not Covered
D5919	Facial prosthesis	$350	Not Covered
D5922	Nasal septal prosthesis	$350	Not Covered
D5923	Ocular prosthesis, interim	$350	Not Covered
D5924	Cranial prosthesis	$350	Not Covered
D5925	Facial augmentation implant prosthesis	$200	Not Covered
D5926	Nasal prosthesis, replacement	$200	Not Covered
D5927	Auricular prosthesis, replacement	$200	Not Covered
D5928	Orbital prosthesis, replacement	$200	Not Covered
D5929	Facial prosthesis, replacement	$200	Not Covered
D5931	Obturator prosthesis, surgical	$350	Not Covered
D5932	Obturator prosthesis, definitive	$350	Not Covered
D5933	Obturator prosthesis, modification	$150	Not Covered
D5934	Mandibular resection prosthesis with guide flange	$350	Not Covered
D5935	Mandibular resection prosthesis without guide flange	$350	Not Covered
D5936	Obturator prosthesis, interim	$350	Not Covered
D5937	Trismus appliance (not for TMD treatment)	$85	Not Covered
D5951	Feeding aid	$135	Not Covered
D5952	Speech aid prosthesis, pediatric	$350	Not Covered
D5953	Speech aid prosthesis, adult	$350	Not Covered
D5954	Palatal augmentation prosthesis	$135	Not Covered
D5955	Palatal lift prosthesis, definitive	$350	Not Covered
D5958	Palatal lift prosthesis, interim	$350	Not Covered
D5959	Palatal lift prosthesis, modification	$145	Not Covered
D5960	Speech aid prosthesis, modification	$145	Not Covered
D5982	Surgical stent	$70	Not Covered
D5983	Radiation carrier	$55	Not Covered
D5984	Radiation shield	$85	Not Covered
D5985	Radiation cone locator	$135	Not Covered
D5986	Fluoride gel carrier	$35	Not Covered
D5987	Commissure splint	$85	Not Covered
D5988	Surgical splint	$95	Not Covered
D5991	Topical Medicament Carrier	$70	Not Covered
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not Covered
D6010	Surgical placement of implant body: endosteal implant	$350	Not Covered
D6011	Second stage implant surgery	$350	Not Covered

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D6013	Surgical placement of mini implant	$350	Not Covered
D6040	Surgical placement: eposteal implant	$350	Not Covered
D6050	Surgical placement: transosteal implant	$350	Not Covered
D6052	Semi-precision attachment abutment	$350	Not Covered
D6055	Connecting bar - implant supported or abutment supported	$350	Not Covered
D6056	Prefabricated abutment - includes modification and placement	$135	Not Covered
D6057	Custom fabricated abutment - includes placement	$180	Not Covered
D6058	Abutment supported porcelain/ceramic crown	$320	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	$315	Not Covered
D6065	Implant supported porcelain/ceramic crown	$340	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335	Not Covered
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not Covered
D6075	Implant supported retainer for ceramic FPD	$335	Not Covered
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330	Not Covered
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350	Not Covered
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30	Not Covered
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	Not Covered
D6085	Provisional implant crown	$300	Not Covered
D6090	Repair implant supported prosthesis, by report	$65	Not Covered
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	Not Covered
D6092	Recement implant/abutment supported crown	$25	Not Covered
D6093	Recement implant/abutment supported fixed partial denture	$35	Not Covered
D6094	Abutment supported crown (titanium)	$295	Not Covered
D6095	Repair implant abutment, by report	$65	Not Covered
D6096	Remove broken implant retaining screw	$60	Not Covered
D6100	Implant removal, by report	$110	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	Not Covered

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D6190	Radiographic/Surgical implant index, by report	$75	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium)	$265	Not Covered
D6199	Unspecified implant procedure, by report	$350	Not Covered
D6205	Pontic - indirect resin based composite	Not Covered	$165
D6210	pontic - cast high noble metal	Not Covered	$300
D6211	pontic - cast predominantly base metal	$300	$300
D6212	pontic - cast noble metal	Not Covered	$300
D6214	Pontic - cast titanium metal	Not Covered	$300
D6240	pontic - porcelain fused to high noble metal	Not Covered	$300
D6241	pontic - porcelain fused to predominantly base metal	$300	$300
D6242	pontic - porcelain fused to noble metal	Not Covered	$300
D6245	Pontic - porcelain/ceramic	$300	$300
D6250	Pontic - resin with high noble metal	Not Covered	$300
D6251	pontic - resin with predominantly base metal	$300	$300
D6252	Pontic - resin with noble metal	Not Covered	$300
D6545	retainer - cast metal for resin bonded fixed prosthesis	Not Covered	$130
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	$145
D6549	Retainer – for resin bonded fixed prosthesis	Not Covered	$130
D6608	Onlay - porcelain/ceramic - two surfaces	Not Covered	$200
D6609	Onlay - porcelain/ceramic - three or more surfaces	Not Covered	$200
D6610	Onlay - cast high noble metal - two surfaces	Not Covered	$200
D6611	Onlay - cast high noble metal - three or more surfaces	Not Covered	$200
D6612	Onlay - cast predominantly base metal - two surfaces	Not Covered	$200
D6613	Onlay - cast predominantly base metal - three or more surfaces	Not Covered	$200
D6614	Onlay - cast noble metal- two surfaces	Not Covered	$200
D6615	Onlay - cast noble metal - three or more surfaces	Not Covered	$200
D6634	Onlay - titanium	Not Covered	$200
D6710	Crown - indirect resin based composite	Not Covered	$200
D6720	crown - resin with high noble metal	Not Covered	$300
D6721	crown - resin with predominantly base metal	$300	$300
D6722	crown - resin with noble metal	Not Covered	$300
D6740	crown - porcelain/ceramic	$300	$300
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	$300
D6751	crown - porcelain fused to predominantly base metal	$300	$300
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	$300
D6781	crown - 3/4 cast predominantly base metal	$300	$300
D6782	crown - 3/4 cast noble metal	Not Covered	$300
D6783	crown - 3/4 porcelain/ceramic	$300	$300
D6791	crown - full cast predominantly base metal	$300	$300
D6930	Recement bridge	$40	$40
D6980	fixed partial denture repair necessitated by restorative material failure	$95	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350	Not Covered
D7111	Extraction, coronal remnants - deciduous tooth	$40	$40
D7140	extraction, erupted tooth or exposed root	$65	$65
D7210	surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	$120	$115
D7220	removal of impacted tooth - soft tissue	$95	$85
D7230	removal of impacted tooth - partially bony	$145	$145

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D7240	removal of impacted tooth - completely bony	$160	$160
D7241	Removal of impacted tooth - complete bony with unusual surgical complications	$175	$175
D7250	surgical removal of residual tooth roots requiring cutting of soft tissue and bone and	$80	$75
D7260	Oral Antral Fistula Closure	$280	$280
D7261	Primary closure of a sinus perforation	$285	Not Covered
D7270	tooth reimplantation / stabilization	$185	Not Covered
D7280	Surgical access of an unerupted tooth	$220	Not Covered
D7283	Placement of device to facilitate eruption of impacted tooth	$85	Not Covered
D7285	biopsy of oral tissue - hard (bone, tooth)	$180	Not Covered
D7286	biopsy of oral tissue - soft	$110	$110
D7287	Exfoliative cytological sample collection	Not Covered	$35
D7288	Brush biopsy transepithelial sample collection	Not Covered	$35
D7290	Surgical repositioning of teeth	$185	Not Covered
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	Not Covered
D7310	alveoloplasty in conjunction with extractions – per quadrant	$85	$85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per	$50	$50
D7320	alveoloplasty not in conjunction with extractions – per quadrant	$120	$120
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350	Not Covered
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	Not Covered
D7410	excision of benign lesion up to 1.25 cm	$75	Not Covered
D7411	excision of benign lesion greater than 1.25 cm	$115	Not Covered
D7412	Excision of benign lesion, complicated	$175	Not Covered
D7413	Excision of malignant lesion up to 1.25 cm	$95	Not Covered
D7414	Excision of malignant lesion greater than 1.25 cm	$120	Not Covered
D7415	Excision of malignant lesion, complicated	$255	Not Covered
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105	Not Covered
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185	Not Covered
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	Not Covered
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	Not Covered
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	Not Covered
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	Not Covered
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	Not Covered
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140
D7472	Removal of Torus Palatinus	$145	$140
D7473	Removal of torus mandibularis	$140	$140
D7485	Surgical reduction of osseous tuberosity	$105	Not Covered
D7490	Radical resection of maxilla or mandible	$350	Not Covered
D7510	incision and drainage of abscess - intraoral soft tissue	$70	$55
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	$70	$69
D7520	incision and drainage of abscess - extraoral soft tissue	$70	Not Covered
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	Not Covered
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	Not Covered
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	Not Covered
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	Not Covered

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D7610	Maxilla – open reduction (teeth immobilized, if present)	$140	Not Covered
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250	Not Covered
D7630	Mandible – open reduction (teeth immobilized, if present)	$350	Not Covered
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350	Not Covered
D7650	Malar and/or zygomatic arch – open reduction	$350	Not Covered
D7660	Malar and/or zygomatic arch – closed reduction	$350	Not Covered
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170	Not Covered
D7671	Alveolus – open reduction, may include stabilization of teeth	$230	Not Covered
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	Not Covered
D7710	Maxilla – open reduction	$110	Not Covered
D7720	Maxilla – closed reduction	$180	Not Covered
D7730	Mandible – open reduction	$350	Not Covered
D7740	Mandible – closed reduction	$290	Not Covered
D7750	Malar and/or zygomatic arch – open reduction	$220	Not Covered
D7760	Malar and/or zygomatic arch – closed reduction	$350	Not Covered
D7770	Alveolus – open reduction stabilization of teeth	$135	Not Covered
D7771	Alveolus, closed reduction stabilization of teeth	$160	Not Covered
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	Not Covered
D7810	Open reduction of dislocation	$350	Not Covered
D7820	Closed reduction of dislocation	$80	Not Covered
D7830	Manipulation under anesthesia	$85	Not Covered
D7840	Condylectomy	$350	Not Covered
D7850	Surgical discectomy, with/without implant	$350	Not Covered
D7852	Disc repair	$350	Not Covered
D7854	Synovectomy	$350	Not Covered
D7856	Myotomy	$350	Not Covered
D7858	Joint reconstruction	$350	Not Covered
D7860	Arthrostomy	$350	Not Covered
D7865	Arthroplasty	$350	Not Covered
D7870	Arthrocentesis	$90	Not Covered
D7871	Non-arthroscopic lysis and lavage	$150	Not Covered
D7872	Arthroscopy – diagnosis, with or without biopsy	$350	Not Covered
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350	Not Covered
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350	Not Covered
D7875	Arthroscopy – surgical: synovectomy	$350	Not Covered
D7876	Arthroscopy – surgical: discectomy	$350	Not Covered
D7877	Arthroscopy – surgical: debridement	$350	Not Covered
D7880	Occlusal orthotic device, by report	$120	Not Covered
D7881	Occlusal orthotic device adjustment	$30	Not Covered
D7899	Unspecified TMD therapy, by report	$350	Not Covered
D7910	Suture of recent small wounds up to 5 cm	$35	Not Covered
D7911	Complicated suture – up to 5 cm	$55	Not Covered
D7912	Complicated suture – greater than 5 cm	$130	Not Covered
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not Covered
D7940	Osteoplasty – for orthognathic deformities	$160	Not Covered
D7941	Osteotomy – mandibular rami	$350	Not Covered
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350	Not Covered

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D7944	Osteotomy – segmented or subapical	$275	Not Covered
D7945	Osteotomy – body of mandible	$350	Not Covered
D7946	LeFort I (maxilla – total)	$350	Not Covered
D7947	LeFort I (maxilla – segmented)	$350	Not Covered
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350	Not Covered
D7949	LeFort II or LeFort III – with bone graft	$350	Not Covered
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190	Not Covered
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not Covered
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175	Not Covered
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not Covered
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure	$120	$120
D7963	Frenuloplasty	$120	$120
D7970	Excision of hyperplastic tissue - per arch	$175	$176
D7971	Excision of pericoronal gingival	$80	$80
D7972	Surgical reduction of fibrous tuberosity	$100	Not Covered
D7979	Non-surgical Sialolithotomy	$155	$155
D7980	Sialolithotomy	$155	Not Covered
D7981	Excision of salivary gland, by report	$120	Not Covered
D7982	Sialodochoplasty	$215	Not Covered
D7983	Closure of salivary fistula	$140	Not Covered
D7990	Emergency tracheotomy	$350	Not Covered
D7991	Coronoidectomy	$345	Not Covered
D7995	Synthetic graft – mandible or facial bones, by report	$150	Not Covered
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not Covered
D7999	Unspecified oral surgery procedure, by report	$350	Not Covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$350	Not Covered
D8210	Removable appliance therapy		
D8220	Fixed appliance therapy		
D8660	Pre-orthodontic treatment visit		
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		
D8681	Removable orthodontic retainer adjustment		
D8691	Repair of orthodontic appliance		
D8692	Replacement of lost or broken retainer		
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers		
D8694	Repair of fixed retainers, includes reattachment		
D8999	Unspecified orthodontic procedure, by report		
D9110	palliative (emergency) treatment of dental pain - minor procedure	$30	$28
D9120	Fixed partial denture sectioning	$95	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10	$10
D9211	Regional block anesthesia	$20	$20
D9212	Trigeminal division block anesthesia	$60	$60
D9215	local anesthesia	$15	$15
D9222	Deep sedation/analgesia - first 15 minute	$45	$45
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45	$45
D9230	analgesia nitrous oxide	$15	Not Covered

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D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	$45
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$60	$45
D9248	non-intravenous conscious sedation	$65	Not Covered
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	$45
D9311	Consultation with a medical health professional	No Charge	Not Covered
D9410	House/Extended care facility call	$50	Not Covered
D9420	Hospital or ambulatory surgical center call	$135	Not Covered
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$20	$12
D9440	office visit - after regularly scheduled hours	$45	$40
D9450	Case presentation	Not Covered	No Charge
D9610	Therapeutic parenteral drug, single administration	$30	Not Covered
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40	Not Covered
D9910	Application of desensitizing medicament	$20	$22
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35	Not Covered
D9942	Repair and/or reline of occlusal guard	Not Covered	$35
D9943	Occlusal guard adjustment	Not Covered	$35
D9944	Occlusal guard hard appliance, full arch	Not Covered	$115
D9945	Occlusal guard soft appliance, full arch	Not Covered	$115
D9946	Occlusal guard hard appliance, partial arch	Not Covered	$115
D9950	Occlusion analysis – mounted case	$120	Not Covered
D9951	Occlusal adjustment - limited	$45	$45
D9952	Occlusal adjustment - complete	$210	$210
D9995	Teledentistry - synchronous; real-time encounter	Not Covered	No Charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Not Covered	No Charge
D9999	unspecified adjunctive procedure, by report	No Charge	Not Covered

Endnotes to 2020 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
5) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

6) Tooth whitening, adult orthodontia, implants, veneers, and adult services noted as Not Covered on the Copayment Schedule are not covered services.
7) The six month waiting period for major services must be waived upon a member's provision of proof of prior comprehensive dental coverage. This waiting period shall be prorated on a one to one monthly basis upon a member's provision of proof of prior comprehensive dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage.

Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month waiting period would no longer occur. Dental services obtained via a discount health plan are not considered “comprehensive” dental coverage for purposes of counting towards the waiting period.