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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Child</td>
<td>Adult</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 and</td>
<td>19+</td>
</tr>
<tr>
<td>D0230</td>
<td>intraoral - periapical each additional radiographic image</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0240</td>
<td>intraoral - occlusal radiographic image</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0250</td>
<td>extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector</td>
<td>No</td>
<td>No</td>
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<tr>
<td>D0270</td>
<td>bitewing - single radiographic image</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0272</td>
<td>bitewings - two radiographic images</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0273</td>
<td>bitewings - three radiographic images</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0274</td>
<td>bitewings - four radiographic images</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0277</td>
<td>vertical bitewings - 7 to 8 radiographic images</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0310</td>
<td>sialography</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0320</td>
<td>temporomandibular joint arthrogram, including injection</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0322</td>
<td>tomographic survey</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0330</td>
<td>panoramic radiographic image</td>
<td>No</td>
<td>Charge</td>
</tr>
<tr>
<td>D0340</td>
<td>2D cephalometric radiographic image – acquisition, measurement and analysis</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0350</td>
<td>2D oral/facial photographic image obtained intra-orally or extra-orally</td>
<td>No</td>
<td>Not Covered</td>
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<tr>
<td>D0431</td>
<td>adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures</td>
<td>Not Covered</td>
<td>No</td>
</tr>
<tr>
<td>D0460</td>
<td>pulp vitality tests</td>
<td>No</td>
<td>Charge</td>
</tr>
<tr>
<td>D0470</td>
<td>diagnostic casts</td>
<td>No</td>
<td>Charge</td>
</tr>
<tr>
<td>D0502</td>
<td>other oral pathology procedures, by report</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0601</td>
<td>caries risk assessment and documentation, with a finding of low risk</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0602</td>
<td>caries risk assessment and documentation, with a finding of moderate risk</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0603</td>
<td>caries risk assessment and documentation, with a finding of high risk</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0999</td>
<td>unspecified diagnostic procedure, by report</td>
<td>No</td>
<td>Charge</td>
</tr>
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</table>

### Diagnostic Procedures

Please see the attached Exclusions and Limitations for more information.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Child</td>
<td>Adult</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 and</td>
<td>19+</td>
</tr>
<tr>
<td>D0120</td>
<td>periodic oral evaluation - established patient</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0140</td>
<td>limited oral evaluation - problem focused</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0145</td>
<td>oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>No</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0150</td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0160</td>
<td>detailed and extensive oral evaluation - problem focused, by report</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0170</td>
<td>re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0180</td>
<td>comprehensive periodontal evaluation - new or established patient</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0190</td>
<td>screening of a patient</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D0191</td>
<td>assessment of a patient</td>
<td>Not Covered</td>
<td>No</td>
</tr>
<tr>
<td>D0210</td>
<td>intraoral - complete series of radiographic images</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>D0220</td>
<td>intraoral - periapical first radiographic image</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

All procedures listed other than those indicated as "Not Covered" are pediatric essential health benefit services. Copayments for pediatric essential health benefit services apply to the pediatric member out-of-pocket-maximum.

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

Services must be performed by your selected Dental Health Services participating dentist. Please contact your Member Services Specialist at 855-495-0905 if you need assistance in choosing a dentist. All referrals for specialist services must be requested by your participating dentist and pre-authorized by Dental Health Services.
## Preventive Procedures

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment Child 18 and under</th>
<th>Adult 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - child</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1206</td>
<td>topical application of fluoride varnish</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1208</td>
<td>topical application of fluoride – excluding varnish</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1310</td>
<td>nutritional counseling for control of dental disease</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1320</td>
<td>tobacco counseling for the control and prevention of oral disease</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1330</td>
<td>oral hygiene instructions</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1351</td>
<td>sealant - per tooth</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1352</td>
<td>preventive resin restoration in a moderate to high caries risk patient – permanent tooth</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1510</td>
<td>space maintainer - fixed - unilateral</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1515</td>
<td>space maintainer - fixed - bilateral</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1520</td>
<td>space maintainer - removable - unilateral</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1525</td>
<td>space maintainer - removable - bilateral</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1550</td>
<td>re-cement or re-bond space maintainer</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D1555</td>
<td>removal of fixed space maintainer</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

## Restorative Procedures

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment Child 18 and under</th>
<th>Adult 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>amalgam - one surface, primary or permanent</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>D2150</td>
<td>amalgam - two surfaces, primary or permanent</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>D2160</td>
<td>amalgam - three surfaces, primary or permanent</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>D2161</td>
<td>amalgam - four or more surfaces, primary or permanent</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>D2330</td>
<td>resin-based composite - one surface, anterior</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>D2331</td>
<td>resin-based composite - two surfaces, anterior</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>D2332</td>
<td>resin-based composite - three surfaces, anterior</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>D2335</td>
<td>resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>D2370</td>
<td>resin-based composite crown, anterior</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>D2391</td>
<td>resin-based composite - one surface, posterior</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>D2392</td>
<td>resin-based composite - two surfaces, posterior</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>D2393</td>
<td>resin-based composite - three surfaces, posterior</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>D2394</td>
<td>resin-based composite - four or more surfaces, posterior</td>
<td>70</td>
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<tr>
<td>D242</td>
<td>onlay - metallic - two surfaces</td>
<td>Not Covered</td>
<td>185</td>
</tr>
<tr>
<td>D243</td>
<td>onlay - metallic - three surfaces</td>
<td>Not Covered</td>
<td>200</td>
</tr>
<tr>
<td>D244</td>
<td>onlay - metallic - four or more surfaces</td>
<td>Not Covered</td>
<td>215</td>
</tr>
<tr>
<td>D246</td>
<td>onlay - porcelain/ceramic - two surfaces</td>
<td>Not Covered</td>
<td>250</td>
</tr>
<tr>
<td>D2463</td>
<td>onlay - porcelain/ceramic - three surfaces</td>
<td>Not Covered</td>
<td>275</td>
</tr>
<tr>
<td>D264</td>
<td>onlay - porcelain/ceramic - four or more surfaces</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2662</td>
<td>onlay - resin-based composite - two surfaces</td>
<td>Not Covered</td>
<td>160</td>
</tr>
<tr>
<td>D2663</td>
<td>onlay - resin-based composite - three surfaces</td>
<td>Not Covered</td>
<td>180</td>
</tr>
<tr>
<td>D2664</td>
<td>onlay - resin-based composite - four or more surfaces</td>
<td>Not Covered</td>
<td>200</td>
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<tr>
<td>D2710</td>
<td>crown - resin-based composite (indirect)</td>
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<tr>
<td>D2712</td>
<td>crown - ¾ resin-based composite (indirect)</td>
<td>190</td>
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<tr>
<td>D2720</td>
<td>crown - resin with high noble metal</td>
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<td>300</td>
</tr>
<tr>
<td>D2721</td>
<td>crown - resin with predominantly base metal</td>
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<td>300</td>
</tr>
<tr>
<td>D2722</td>
<td>crown - resin with noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2740</td>
<td>crown - porcelain/ceramic substrate</td>
<td>300</td>
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</tr>
<tr>
<td>D2750</td>
<td>crown - porcelain fused to high noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2751</td>
<td>crown - porcelain fused to predominantly base metal</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>D2752</td>
<td>crown - porcelain fused to noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2780</td>
<td>crown - 3/4 cast high noble metal</td>
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<td>300</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Copayment Child 18 and under</td>
<td>Copayment Adult 19+</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>D2781</td>
<td>crown - 3/4 cast predominantly base metal</td>
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<td>300</td>
</tr>
<tr>
<td>D2782</td>
<td>crown - 3/4 cast noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2783</td>
<td>crown - 3/4 porcelain/ceramic</td>
<td>310</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D2790</td>
<td>crown - full cast high noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2791</td>
<td>crown - full cast predominantly base metal</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>D2792</td>
<td>crown - full cast noble metal</td>
<td>Not Covered</td>
<td>300</td>
</tr>
<tr>
<td>D2910</td>
<td>re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>D2915</td>
<td>re-cement or re-bond indirectly fabricated or prefabricated post and core</td>
<td>25</td>
<td>25</td>
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<tr>
<td>D2920</td>
<td>re-cement or re-bond crown</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>D2929</td>
<td>prefabricated porcelain/ceramic crown – primary tooth</td>
<td>95</td>
<td>Not Covered</td>
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<tr>
<td>D2930</td>
<td>prefabricated stainless steel crown - primary tooth</td>
<td>65</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D2931</td>
<td>prefabricated stainless steel crown - permanent tooth</td>
<td>75</td>
<td>75</td>
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<tr>
<td>D2932</td>
<td>prefabricated resin crown</td>
<td>75</td>
<td>Not Covered</td>
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<tr>
<td>D2933</td>
<td>prefabricated stainless steel crown with resin window</td>
<td>80</td>
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</tr>
<tr>
<td>D2940</td>
<td>protective restoration</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>D2950</td>
<td>core buildup, including any pins when required</td>
<td>20</td>
<td>20</td>
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<tr>
<td>D2951</td>
<td>pin retention - per tooth, in addition to restoration</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>D2952</td>
<td>post and core in addition to crown, indirectly fabricated</td>
<td>100</td>
<td>60</td>
</tr>
<tr>
<td>D2953</td>
<td>each additional indirectly fabricated post - same tooth</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>D2954</td>
<td>prefabricated post and core in addition to crown</td>
<td>90</td>
<td>60</td>
</tr>
<tr>
<td>D2955</td>
<td>post removal</td>
<td>60</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D2957</td>
<td>each additional prefabricated post - same tooth</td>
<td>35</td>
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<tr>
<td>D2971</td>
<td>additional procedures to construct new crown under existing partial denture framework</td>
<td>35</td>
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<tr>
<td>D2980</td>
<td>crown repair necessitated by restorative material failure</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>D2999</td>
<td>unspecified restorative procedure, by report</td>
<td>40</td>
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</tbody>
</table>

**Endodontic Procedures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment Child 18 and under</th>
<th>Copayment Adult 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>pulp cap - direct (excluding final restoration)</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>D3120</td>
<td>pulp cap - indirect (excluding final restoration)</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>D3220</td>
<td>therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>D3221</td>
<td>pulpal debridement, primary and permanent teeth</td>
<td>40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3222</td>
<td>partial pulpotomy for apexogenesis - permanent tooth with incomplete root development</td>
<td>60</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3230</td>
<td>pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)</td>
<td>55</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3240</td>
<td>pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</td>
<td>55</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3310</td>
<td>endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>195</td>
<td>200</td>
</tr>
<tr>
<td>D3320</td>
<td>endodontic therapy, bicuspid tooth (excluding final restoration)</td>
<td>235</td>
<td>235</td>
</tr>
<tr>
<td>D3330</td>
<td>endodontic therapy, molar (excluding final restoration)</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>D3331</td>
<td>treatment of root canal obstruction; nonsurgical access</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>D3332</td>
<td>incomplete endodontic therapy; inoperable, unrestorable or fractured</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>D3333</td>
<td>internal root repair of perforation defects</td>
<td>80</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3346</td>
<td>retreatment of previous root canal therapy - anterior</td>
<td>240</td>
<td>245</td>
</tr>
<tr>
<td>D3347</td>
<td>retreatment of previous root canal therapy - bicuspid</td>
<td>295</td>
<td>295</td>
</tr>
<tr>
<td>D3348</td>
<td>retreatment of previous root canal therapy - molar</td>
<td>365</td>
<td>365</td>
</tr>
<tr>
<td>D3351</td>
<td>apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)</td>
<td>85</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D3352</td>
<td>apexification/recalcification – interim medication replacement</td>
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<td>canal preparation and fitting of preformed dowel or post</td>
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Effective Date: 1/1/2017
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<td>bone replacement graft – retained natural tooth – first site in quadrant</td>
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<td>biologic materials to aid in soft and osseous tissue regeneration</td>
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<td>guided tissue regeneration - resorbable barrier, per site</td>
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<td>pedicle soft tissue graft procedure</td>
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<td>autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft</td>
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<td>full mouth debridement to enable comprehensive evaluation and diagnosis of localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth</td>
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<td>adjust complete denture - mandibular</td>
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<td>repair broken complete denture base</td>
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<td>replace missing or broken teeth - complete denture (each tooth)</td>
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<td>D5610</td>
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<td>D5630</td>
<td>repair or replace broken clasp - per tooth</td>
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<td>replace broken teeth - per tooth</td>
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<td>add tooth to existing partial denture</td>
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<td>D5670</td>
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Effective Date: 1/1/2017
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**Maxillofacial Prosthetic Procedures**

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Effective Date: 1/1/2017
### Implant Service Procedures

*Please see the attached Exclusions and Limitations for more information.*

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<th>Copayment Adult 19+</th>
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<td>surgical placement: transosteal implant</td>
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<td>connecting bar – implant supported or abutment supported</td>
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<td>custom fabricated abutment – includes placement</td>
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<td>unspecified implant procedure, by report</td>
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### Fixed Prosthodontic Procedures

*Please see the attached Exclusions and Limitations for more information.*

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**Oral and Maxillofacial Surgery Procedures**

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<td>D7111</td>
<td>extraction, coronal remnants - deciduous tooth</td>
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<td>D7140</td>
<td>extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
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<td>D7210</td>
<td>extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
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<td>D7220</td>
<td>removal of impacted tooth - soft tissue</td>
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<td>D7230</td>
<td>removal of impacted tooth - partially bony</td>
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<td>D7240</td>
<td>removal of impacted tooth - completely bony</td>
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<td>D7241</td>
<td>removal of impacted tooth - completely bony, with unusual surgical complications</td>
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<td>D7250</td>
<td>removal of residual tooth roots (cutting procedure)</td>
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<td>D7260</td>
<td>oroantral fistula closure</td>
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<td>D7261</td>
<td>primary closure of a sinus perforation</td>
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<td>tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
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<td>D7280</td>
<td>exposure of an unerupted tooth</td>
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<td>D7283</td>
<td>placement of device to facilitate eruption of impacted tooth</td>
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<td>D7285</td>
<td>incisional biopsy of oral tissue-hard (bone, tooth)</td>
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<td>D7286</td>
<td>incisional biopsy of oral tissue-soft</td>
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<td>D7287</td>
<td>exfoliative cytological sample collection</td>
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<td>brush biopsy - transepithelial sample collection</td>
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<td>D7291</td>
<td>transseptal fiberotomy supra crestal fiberotomy, by report</td>
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Effective Date: 1/1/2017
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<td>alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
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<td>alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
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<td>alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
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<td>vestibuloplasty - ridge extension (secondary epithelialization)</td>
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<td>vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)</td>
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<td>D7410</td>
<td>excision of benign lesion up to 1.25 cm</td>
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<td>D7411</td>
<td>excision of benign lesion greater than 1.25 cm</td>
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<td>D7412</td>
<td>excision of benign lesion, complicated</td>
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<td>excision of malignant lesion up to 1.25 cm</td>
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<td>excision of malignant lesion, complicated</td>
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<td>excision of malignant tumor - lesion diameter up to 1.25 cm</td>
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<td>destruction of lesion(s) by physical or chemical method, by report</td>
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<td>removal of torus palatinus</td>
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<td>reduction of osseous tuberosity</td>
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<td>maxillary sinusotomy for removal of tooth fragment or foreign body</td>
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</tr>
<tr>
<td>D7830</td>
<td>manipulation under anesthetia</td>
<td>85</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7840</td>
<td>condylectomy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7850</td>
<td>surgical discectomy, with/without implant</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7852</td>
<td>disc repair</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7854</td>
<td>synovectomy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7856</td>
<td>myotomy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7858</td>
<td>joint reconstruction</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7860</td>
<td>arthroscopy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7865</td>
<td>arthroplasty</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7870</td>
<td>arthrocentesis</td>
<td>90</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7871</td>
<td>non-arthroscopic lysis and lavage</td>
<td>150</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7872</td>
<td>arthroscopy - diagnosis, with or without biopsy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7873</td>
<td>arthroscopy: lavage and lysis of adhesions</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7874</td>
<td>arthroscopy: disc repositioning and stabilization</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7875</td>
<td>arthroscopy: synovectomy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7876</td>
<td>arthroscopy: discectomy</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7877</td>
<td>arthroscopy: debridement</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7880</td>
<td>occlusal orthotic device, by report</td>
<td>120</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7899</td>
<td>unspecified TMD therapy, by report</td>
<td>350</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7910</td>
<td>suture of recent small wounds up to 5 cm</td>
<td>35</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7911</td>
<td>complicated suture - up to 5 cm</td>
<td>55</td>
<td>Not Covered</td>
</tr>
<tr>
<td>D7912</td>
<td>complicated suture - greater than 5 cm</td>
<td>130</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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Orthodontic Procedures

*Medically Necessary Orthodontia is covered at a $350 copayment for children 18 and under only. Member cost share for Medically Necessary Orthodontia services applies to the course of treatment, not individual benefit years within a multi-year course of treatment. Member cost share applies to the course of treatment as long as the member remains enrolled in the plan. The following services are included:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080</td>
<td>comprehensive orthodontic treatment of the adolescent dentition</td>
<td></td>
</tr>
<tr>
<td>D8210</td>
<td>removable appliance therapy</td>
<td></td>
</tr>
<tr>
<td>D8220</td>
<td>fixed appliance therapy</td>
<td></td>
</tr>
<tr>
<td>D8660</td>
<td>pre-orthodontic treatment examination to monitor growth and development</td>
<td></td>
</tr>
<tr>
<td>D8670</td>
<td>periodic orthodontic treatment visit</td>
<td></td>
</tr>
<tr>
<td>D8680</td>
<td>orthodontic retention (removal of appliances, construction and placement of retainer(s))</td>
<td></td>
</tr>
<tr>
<td>D8691</td>
<td>repair of orthodontic appliance</td>
<td></td>
</tr>
<tr>
<td>D8692</td>
<td>replacement of lost or broken retainer</td>
<td></td>
</tr>
<tr>
<td>D8693</td>
<td>re-cement or re-bond fixed retainer</td>
<td></td>
</tr>
<tr>
<td>D8999</td>
<td>unspecified orthodontic procedure, by report</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Adjunctive Service Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>palliative (emergency) treatment of dental pain - minor procedure</td>
<td>30 28</td>
</tr>
<tr>
<td>D9120</td>
<td>fixed partial denture sectioning</td>
<td>95 95</td>
</tr>
<tr>
<td>D9210</td>
<td>local anesthesia not in conjunction with operative or surgical procedures</td>
<td>10 10</td>
</tr>
<tr>
<td>D9211</td>
<td>regional block anesthesia</td>
<td>20 20</td>
</tr>
<tr>
<td>D9212</td>
<td>trigeminal division block anesthesia</td>
<td>60 60</td>
</tr>
<tr>
<td>D9215</td>
<td>local anesthesia in conjunction with operative or surgical procedures</td>
<td>15 15</td>
</tr>
<tr>
<td>D9223</td>
<td>deep sedation/general anesthesia – each 15 minute increment</td>
<td>45 45</td>
</tr>
</tbody>
</table>
General Policies

The following services are not covered by your dental plan:

A. Services not consistent with professionally recognized standards of practice.
B. Cosmetic services, for appearance only, unless specifically listed.
C. Treatment for malignancies, as well as hereditary, congenital and/or developmental malformations.
D. Dispensing of drugs not normally supplied in a dental office.
E. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.
F. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.
G. Expenses incurred for dental procedures initiated prior to member’s eligibility with Dental Health Services, or after termination of eligibility.
H. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).
I. Procedures performed by a prosthodontist.
J. Changes in treatment necessitated by an accident of any kind.
K. Coordinator of benefits with another prepaid managed care dental plan.

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

A. Treatment of dental emergencies is limited to treatment that will alleviate acute symptoms and does not cover definitive restorative treatment including, but not limited to root canal treatment and crowns.
B. Optional services: when the patient select a plan of treatment that is considered optional or unnecessary by the attending dentist, the additional cost is the responsibility of the patient.
C. Specialty referrals must be pre-approved by Dental Health Services for any treatment deemed necessary by the treating participating dentist.
D. Pre-authorization is required for all specialty services.
E. Tooth whitening, adult orthodontia, and implants are not covered services.
F. Services not specifically listed, or listed as Not Covered in the Schedule of Covered Services and Copayments.

Diagnostic General Policies (D0100-D0999)

A. D0120 is a benefit once every 6 months, per participating dentist or after six months have elapsed following comprehensive oral evaluation (D0150) with the same participating dentist.
B. D0140 and D0160 are a benefit once per member per participating dentist.
C. D0170 is a benefit up to six (6) in a three (3) month period, up to a maximum of 12 times in a twelve (12) month period.
   1. This procedure is not covered when provided on the same date of service as D0120, D0140, D0150, D0160, or D9430.
D. D0210 is a benefit once per participating dentist every thirty-six (36) months.
   1. D0210 is not a benefit to the same participating dentist within six (6) months of D0272 and D0274.
E. D0220 is a benefit to a maximum of 20 periapicals in a twelve (12) month period to the same participating dentist, in any combination of D0220 and D0330.
   1. D0210 is not considered against the maximum of 20 periapicals in a twelve (12) month period.
   2. D0220 is payable once per participating dentist per date of service.
F. D0230 is a benefit to a maximum of 20 periapicals in a twelve (12) month period to the same participating dentist, in any combination of D0220 and D0330.
   1. D0210 is not considered against the maximum of 20 periapicals in a twelve (12) month period.
   2. D0220 is payable once per participating dentist per date of service.
G. D0240 is a benefit up to a maximum of two (2) in a six (6) month period per participating dentist.
H. D0250 and D0270 are a benefit once per date of service.
I. D0272 is a benefit once every six (6) months per participating dentist. D0272 is not a benefit:
   1. within six (6) months of D0210, same participating dentist
   2. for a totally edentulous area.
J. D0274 is a benefit once every six (6) months per participating dentist. D0274 is not a benefit:
   1. within six (6) months of D0210, same participating dentist
   2. for members under the age of ten (10).
K. D0290 and D0320 are a benefit for a maximum of three (3) per date of service.
L. D0322 is a benefit twice in a twelve (12) month period, per participating dentist.
M. D0330 is a benefit once in a thirty-six (36) month period, per participating dentist except when documented as essential for a follow-up/post-operative exam.
   1. D0330 is not a benefit for the same participating dentist on the same date of service as D0210.
   2. D0330 shall be considered part of D0210 when taken on the same date of service with bitewings (D0272 and D0274) and a minimum of two (2) D0230 procedures.
N. D0340 is a benefit twice in a twelve (12) month period per participating dentist.
O. D0350 is a benefit up to a maximum of four (4) per date of service.

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

Preventive General Policies (D1000-D1999)

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

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

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

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

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

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

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

H. D1515 and D1525 are a benefit for pediatric members, 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. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance, such as lost or non-repairable. D1515 is not a benefit:
   1. when the permanent tooth is near eruption or is missing.
   2. for upper and lower anterior teeth.
   3. for orthodontic or tooth guidance appliances.
   4. for minor tooth movement, or
   5. for activating wires.

I. D1550 is a benefit for pediatric members, per applicable quadrant or arch. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition, such as displacement due to a sticky food item.

Restorative General Policies (D2000-D2999)

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

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

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

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

2. permanent posterior teeth (ages 21 and older):
   a. once in a five (5) year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests.
   d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).
   e. D2710 and D2712 are not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

E. D2721, D2740, D2751, D2781, D2783, and D2791 are a benefit as outlined below:
   1. permanent anterior teeth for members thirteen (13) years of age and older and permanent posterior teeth for members ages thirteen (13) through twenty (20):
      a. once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. D2721, D2740, D2751, D2781, D2783, and D2791 are not a benefit for pediatric members under the age of thirteen (13), for third molars unless the 3rd molar occupies 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
   2. permanent posterior teeth (ages 21 and older):
      a. Once in a five (5) year period.
      b. for any resin based composite crown that is indirectly fabricated.
      c. Only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests.
      d. When the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).
      e. D2710 and D2712 are not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

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

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

H. D2929 and D2930 are a benefit once in a twelve Month period.
   I. D2931 is a benefit once in a thirty-six (36) month period. D2931 is not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
   J. D2932 is a benefit once in a twelve (12) month period for primary teeth and once in a thirty-six (36) month period for permanent teeth. D2932 is not a benefit for 3rd molars unless the 3rd molars occupy the 1st or 2nd molar position.

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

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

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

N. D2952 and D2954 are a benefit once per tooth Regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or lab processed) on root canal treated permanent teeth.

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

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

**Endodontic General Policies (D3000-D3999)**

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

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

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

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

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

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

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

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

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

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

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

**Periodontal General Policies (D4000-D4999)**

A. D4210, D4211, D4260, and D4261 are a benefit for members ages thirteen (13) and older, once per quadrant Every thirty-six (36) months. These procedures Require prior-authorization and cannot be prior-authorized within thirty (30) days following periodontal scaling and root planing (D4341/D4342) for the (same quadrant. D4260 and D4261 can only be prior-authorized when preceded by D4341/D4342 in the same quadrant within the previous twenty-four (24) months.

B. D4341 and D4342 are a benefit for members ages thirteen (13) and older, once per quadrant
every twenty-four (24) months. D4210, D4211, D4260, and D4261 cannot be prior-authorized within thirty (30) days following these procedures for the same quadrant.

1. Prophylaxis (D1110/D1120) are not payable on the same date of service.

C. D4910 is a benefit once in a calendar quarter and only when preceded by a completion of all necessary scaling and root planing (D4341/D4342); only in the twenty-four (24) month period following the last scaling and root planing.

1. D4910 is not a benefit in the same calendar quarter as D4341/D4342 and is not payable to the same participating dentist in the same calendar quarter as D1110/D1120.

2. D4910 is considered a full mouth treatment.

D. D4920 is a benefit for members ages 13 and older, once per member per participating dentist within thirty (30) days of the date of service of D4210, D4211, D4260, and D4261.

1. D4920 by the same provider are considered Part of, and included in the fee for D4210, D4211, D4260, and D4261.

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

**Prosthodontics (Removable) General Policies (D5000-D5899)**

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

B. D5130 and D5140 are a benefit once per member, all adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure. D5130/D5140 are not a benefit under the following circumstances:

1. as a temporary denture.
2. subsequent complete dentures within a five (5) year period of an immediate denture.

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

1. five (5) permanent posterior missing teeth, (excluding 3rd molars).
2. all four 1st and 2nd permanent molars missing.
3. 1st and 2nd permanent molars and bicuspids missing on the same side.

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

D. D5213 and D5214 are a benefit once in a five (5) year period and when opposing a full denture and the arch lacks posterior balanced occlusion. All adjustments made within six (6) months after the date of service, by the same participating dentist, are included in the fee for this procedure. Lack of posterior balanced occlusion is defined as follows:

1. five (5) permanent posterior missing teeth, (excluding 3rd molars).
2. all four 1st and 2nd permanent molars missing.
3. 1st and 2nd permanent molars and bicuspids missing on the same side.

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

E. D5510 is a benefit once per arch, per date of service per participating dentist twice in a twelve (12) month period, per participating dentist. All adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

1. D5410 is not a benefit on the same date of service or within six (6) months as D5110 or D5130, D5730, D5740, D5750, D5850, D5510, or D5520.
2. D5411 is not a benefit on the same date of service or within six (6) months as D5120 or D5140, D5731, D5741, D5751, D5851, D5510, or D5520.
3. D5421 is not a benefit on the same date of service or within six (6) months as D5211 or D5213, D5740, D5760, D5850, D5610, D5620, D5630, D5640, D5650, or D5660.
4. D5422 is not a benefit on the same date of service or within six (6) months as D5212 or D5214, D5741, D5761, D5851, D5610, D5620, D5630, D5640, D5650, or D5660.

E. D5510 is a benefit once per arch, per date of service per participating dentist, twice in a twelve (12) month period per participating dentist. All adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

1. D5510 is not a benefit on the same date of service as D5730, D5731, D5750 or D5751.

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

G. D5610 is a benefit once per arch, per date of service per participating dentist, and twice per arch in a 12 month period per participating dentist for partial dentures only. All Adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

1. D5610 is not a benefit on the same date of service as D5740, D5741, D5760 or D5761.

H. D5620 is a benefit once per arch, per date of service per participating dentist, and twice per arch in a 12 month period per participating dentist. All adjustments made within six (6) months after the date of repair, by the same dentist and same arch, are included in the fee for this procedure.

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

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

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

1. Adding 3rd molars is not a benefit.

L. D5730 and D5731 are a benefit once in a twelve (12) month period; six months after the date of service for a removable denture (D5130/D5140) that required extractions or twelve (12) months after the date of service for D5110/D5120 that did not require extractions. D5750 and D5751 are not a benefit under the following circumstance:

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

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

M. D5760 and D5761 are a benefit once in a twelve (12) month period; six months after the date of service for an removable denture (D5213/D5214) that required extractions or twelve (12) months after the date of service for D5213/D5214 that did not require extractions. D5760 and D5761 are not a benefit under the following circumstances:

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

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

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

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

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

O. D5760 and D5761 are a benefit once in a twelve (12) month period; six months after the date of service for an removable denture (D5213/D5214) that required extractions or twelve (12) months after the date of service for D5213/D5214 that did not require extractions. D5760 and D5761 are not a benefit under the following circumstances:

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

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

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

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

Maxillofacial Prosthetic General Policies (D5900-D5999)

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

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

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

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

D. D5933 is a benefit twice in a twelve (12) month Period and not a benefit on the same date of service as D5931, D5932, or D5936.

E. D5951-D5953 are a benefit for pediatric members Under the age of eighteen (18).

F. D5955 is not a benefit on the same date of service as D5958.

G. D5958 is not a benefit on the same date of service as D5955.

H. D5959 is a benefit twice in a twelve (12) month period and not a benefit on the same date of service as D5955 or D5958.

I. D5960 is a benefit twice in a twelve (12) month period and not a benefit on the same date of service as D5952 or D5953.

J. D5999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.

Implant Services General Policies (D6000-D6199)

A. Implant services require prior-authorization and are only a benefit when exceptional medical conditions are documented; each case shall be reviewed for medical necessity.

B. Implant services are only a benefit for pediatric members eighteen (18) years of age and under.

C. Re-cementation of implant/abutment-supported crowns (D6092/D6093) are not a benefit within twelve (12) months of a previous re-cementation by the same participating dentist.

1. the original participating dentist is responsible for all re-cementations within the first twelve (12) months following the initial placement of the implant/abutment-supported crown.

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

Fixed Prosthodontic General Policies (D6200-D6999)

A. D6211, D6241, D6245, and D6251 is a benefit once in a five year (5) period for members thirteen (13) years of age and older and only when the criteria is met for a removable denture (D5211-D5214).

1. D6211 is a benefit only when billed the same date of service as D6721, D6740, D6751, D6781, D6783, and D6791.

B. D6271, D6740, D6751, D6781, D6783, and D6791 are a benefit once in a five (5) year period for members thirteen (13) years of age and older and only when the criteria has been met for a removable denture (D5211-D5214).

C. Re-cementation of a fixed partial denture (D6930) is not a benefit within twelve (12) months of a previous re-cementation by the same participating dentist.

1. the original participating dentist is responsible for all re-cementations within the first twelve (12) months following the initial placement of the fixed partial denture.

D. D6980 is not a benefit within 12 months of the initial placement or previous repair, same participating dentist.

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

Maxillofacial Surgery General Policies (D7000-D7999)

A. D7111 is not a benefit for asymptomatic teeth.

B. D7140 is not a benefit to the same participating dentist who performed the initial tooth extraction.

C. D7260 is not a benefit in conjunction with extractions procedures (D7111-D7250).

D. D7270 is a benefit once per arch regardless of the number of teeth involved and for permanent teeth only. The fee for this service includes splinting and/or stabilization, post-operative care and the removal of the splint or stabilization, by the same participating dentist.

E. D7280 is not a benefit for members ages twenty-one (21) years of age and older or for 3rd molars.

F. D7283 is only a benefit for members in active orthodontic treatment. D7283 is not a benefit under the following circumstances:

1. Members twenty-one (21) years of age and older.
2. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

G. D7285 is a benefit for the removal of specimen only; once per arch, per date of service regardless of the areas involved. D7285 is not a benefit under the following circumstances:

1. an apicoectomy/peridicular surgery D3410-D3426 in the same area, region, or on the same date of service.
2. an extraction D7111-D7250 in the same area, region, or on the same date of service.
3. an excision of any soft tissues or lesions D7410-D7461 in the same area, region, or on the same date of service.

H. D7286 is a benefit for the removal of specimen only; up to a maximum of three (3) per date of
service. D7285 is not a benefit with:
1. an apicoectomy/periradicular surgery D3410-D3426 in the same area, region, or on the same date of service.
2. an extraction D7111-D7250 in the same area, region, or on the same date of service.
3. an excision of any soft tissues or lesions D7410-D7461 in the same area, region, or on the same date of service.
I. D7290 is a benefit for members in active orthodontic treatment, once per arch, on permanent teeth only. D7290 is not a benefit under the following circumstances:
1. members twenty-one (21) years of age and older
2. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
J. D7291 is a benefit only for members in active orthodontic treatment, once per arch and not a benefit for members twenty-one (21) years of age and older.
K. D7310 is a benefit with two (2) or more extractions (D7140-D7250) in the same quadrant, on the same Date of service.
L. D7320 is a benefit regardless of the number of tooth/teeth spaces however, not a benefit within six (6) months following D7140-D7250, in the same quadrant, by the same participating dentist.
M. D7340 and D7350 are a benefit once per arch and not a benefit on the same date of service D7111-D7250 on the same arch.
1. D7340 is not a benefit on the same date of service as D7350 and a limited to once in a five (5) year period.
2. D7350 is not a benefit on the same date of service as D7340.
N. D7471 is a benefit once per quadrant, for the removal of buccal or facial exostosis only.
O. D7472 is a benefit once in the member’s lifetime.
P. D7473 and D7485 is a benefit once per quadrant.
Q. D7510 and D7511 is a benefit once per quadrant, same date of service. The fee for this procedure includes the incision, placement and removal of a surgical draining device.
1. any other definitive treatment performed in the same quadrant on the same date of service, except necessary radiographs, are not a benefit.
R. D7520 and D7521 includes the incision, placement and removal of a surgical draining device.
S. D7530 and D7540 are a benefit once per date of service and not a benefit when associated with the removal of a tumor, cyst (D7440-D7461), or tooth (D7111-D7250).
T. D7550 is a benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. D7550 is not a benefit within thirty (30) days of an associated extraction.
U. D7560 is not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
V. D7610-D7771 include the placement and removal of wires, bands, splints, and arch bars. Anesthesia procedures (D9223-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints, or arch bars.
W. D7780 is a benefit for the treatment of compound fracturess. The fee for this procedure includes the placement and removal of wires, bands, splints, and arch bars. anesthesia procedures (D9223-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints, or arch bars.
X. Anesthesia procedures are a separate benefit when necessary for manipulation under anesthesia (D7830).
Y. D7872 includes the fee for any biopsies performed.
Z. D7880 is a benefit for those diagnosed with TMJ dysfunction however, not a benefit for the treatment of bruxism.
AA. D7899 is not a benefit for procedures such as acupuncture, acupressure, biofeedback, or hypnosis.
BB. D7910-D7912 are not a benefit for the closure of surgical incisions.
CC. D7920, D7950, and D7995 are not a benefit for periodontal grafting.
DD. D7951 and D7952 are a benefit only for members with prior-authorized implant services.
EE. D7960 and D7963 are a benefit once per arch, per date of service and only when the permanent incisors and cusps have erupted.
FF. D7970-D7972 include the fees for other surgical procedures that are performed in the same area, on the same date of service. These procedures are not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
1. D7970 is a benefit once per arch per date of service.
2. D7972 is a benefit once per quadrant per date of service.
GG. D7997 is a benefit once per arch per date of service and for the removal of orthodontic appliances and space maintainers.
HH. D7999 shall be used for a procedure not adequately described by a CDT code; or a procedure that has a CDT code that is not a benefit, but the member has an exceptional medical condition to justify the medical necessity.
Orthodontic General Policies (D8000-D8999)

A. D8080 is a benefit for handicapping malocclusion, cleft palate and facial growth management cases, for pediatric members eighteen (18) and under and permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly), once per member per phase of treatment. All appliances such as bands, arch wires, headgear and palatal expanders are included in the fee for this procedure. This procedure also includes the replacement, repair and removal of brackets, bands, and arch wires by the original participating dentist.

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

C. D8660 is a benefit prior to comprehensive orthodontic treatment (D8080) of the adolescent dentition for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three (3) months, for pediatric members age eighteen (18) and under; for a maximum of six.

D. D8670 is a benefit for pediatric members eighteen (18) years of age and under; for permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter. The maximum quantity of monthly treatment visits for the following phases are:
1. Malocclusion—up to a maximum of eight (8) quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity.
2. Cleft palate-
   a. primary dentition: up to a maximum of four (4) quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
   b. Mixed dentition: up to a maximum of five (5) quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
   c. Permanent dentition: up to a maximum of ten (10) quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

3. Facial growth management-
   a. primary dentition: up to a maximum of four (4) quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
   b. Mixed dentition: up to a maximum of five (5) quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
   c. Permanent dentition: up to a maximum of eight (8) quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

E. D8680 is a benefit for Pediatric members eighteen (18) and under and permanent dentition (unless the member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly), once per arch for each authorized phase of orthodontic treatment. D8680 is not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680). The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

F. D8691 is a benefit for pediatric members eighteen (18) and under, once per appliance. Not a benefit to the original participating dentist for the replacement and/or repair of brackets, bands, or arch wires.

G. D8692 is a benefit for pediatric members eighteen (18) and under; once per arch; only within 24 months following the date of service of orthodontic retention (D8680). This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

H. D8693 is a benefit for pediatric members eighteen (18) and under; once per participating dentist. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition such as displacement due to a sticky food item.

I. D8999 is a benefit for pediatric members eighteen (18) and under and not a benefit to the original participating dentist for the adjustment, repair,
replacement or removal of brackets, bands, or arch wires. Procedure D8999 shall be used for a procedure which is not adequately described by a CDT code, or for a procedure that has a CDT code that is not a benefit but the member has an exceptional medical condition to justify the medical necessity.

**Adjunctive Service General Policies (D9000-D9999)**

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

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

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

D. D9223 is a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgnesia (D9243) or non-intravenous conscious sedation (D9248), when all associated procedures on the same date of service by the same participating dentist are denied.

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

F. D9243 is 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 (D9248), when all associated procedures on the same date of service by the same participating dentist are denied.

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

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

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

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

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

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

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

N. D9930 is a benefit once per date of service per participating dentist, for the removal of bony fragments on the same date of service. 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.

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

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

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

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

Family Dental HMO
Individual Dental Plan

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

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

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

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

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

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

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

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

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

**Emergency Dental Condition:** is determined by an enrollee’s reasonable belief that sudden onset of symptoms in the absence of immediate medical attention could result in permanently placing their health in jeopardy, causing other serious dental or health
consequences, or causing serious impairment of dental function.

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

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

**Limitation:** any provision in this agreement that restricts coverage.

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

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

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

Copayments for covered services received from your participating dentist accumulate through the plan year toward your Out-of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes premium, prescriptions, or dental care your dental plan doesn’t cover. After the pediatric age enrollee meets their OOPM, they will have no further copayments for benefits for the remainder of the calendar year.

If more than one pediatric age enrollee is covered under the contract, copayments made by each individual child for in-network services contribute to the family Out-of-Pocket maximum. Once the amount paid by all pediatric age enrollees equals the OOPM for multiple pediatric age enrollees, no further copayments will be required by any of the pediatric age enrollees for the remainder of the calendar year.
Participating dental office: the office and facilities of the specific Dental Health Services dentist you selected to provide covered services.

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

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

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

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

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

Specialty services: dental services provided by a Dental Health Services contracted or authorized dental specialist (endodontist, periodontist, pedodontist, oral surgeon, or orthodontist). All referrals for covered specialty services must be pre-authorized by Dental Health Services.
Subscriber: a person whose relationship as the primary enrollee is the basis for coverage under this agreement; account responsible.

Urgent care: Prompt care - within 72 hours - for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Your Personal Dental Plan

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

• Encourages treatment by eliminating the burdens of deductibles and plan maximums.
• Makes it easy to receive your dental care without claim forms for most procedures.
• Recognizes receiving regular diagnostic and preventive care with low, or no copayments is the key to better health and long term savings.
• Facilitates care by making all covered services available as soon as membership becomes effective.
• Simplifies access by eliminating pre-authorization for treatment from the general dentist selected from our network of participating dentists.
• Assures availability of care with high-quality, easy-to-find dental offices throughout California. Our network is continually expanding; please contact our office at 855-495-0905 or visit www.dentalhealthservices.com/CA for the latest listing of our participating dentists.
• Allows you to take an active role in your dental health and treatment by fully disclosing coverage and exact copayments prior to treatment.

In addition to your ongoing dental hygiene and care, the following are available for plan members:
• ToothTips™ oral health information sheets.
• Member Service Specialists to assist you by telephone, fax, or e-mail.
• Web access to valuable plan and oral health information at www.dentalhealthservices.com/CA.

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

About Dental Health Services

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

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

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

This matrix is intended to be used to help you compare pediatric essential health benefits coverage and is a summary only.

Your Participating Dentist

Service begins with the selection of local, independently-owned, Quality Assured dental offices. Professional skill, commitment to prevention and wellness, convenience of location, and flexibility in appointment scheduling are some of the most important criteria involved in approving a participating dentist.

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

Your First Dental Appointment

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

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

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

Your Member Service Specialist

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

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

Eligibility

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

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

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

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

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

Disabled dependents enrolling for new coverage may initially be required to show proof of incapacity and dependency, and then not more than annually to ensure the dependent continues to meet the conditions above. Proof must be provided within 60 days of such request. Failure to do so may result in termination of your dependent’s eligibility. Disabled dependent must have been enrolled as a dependent under the subscriber or spouse/domestic partner under a previous health plan at the time the dependent reached the limiting age.

Enrollment

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

Dependents must be added at the time of initial enrollment or during open enrollment. If you experience a qualifying event, you may be eligible for a sixty (60) day special enrollment period. You must report this event within 60 days of the event to Covered California through their web portal at www.coveredca.com for consideration of a sixty (60) day special enrollment period. In the case of birth, adoption or placement for adoption, you have sixty (60) days to report the event to Covered California through the web portal. Covered California may grant you a special enrollment period due to one of the following circumstances:

1. A qualified individual or dependent loses minimum essential dental health benefits. (This excludes loss of coverage due to non-payment);
2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

3. An individual who previously was not a citizen of the United States is granted citizenship;

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

5. An individual is able to adequately demonstrate to Covered California that the individual’s current qualified dental plan substantially violated material provisions of the existing contract between the individual and the qualified dental plan;

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

7. A permanent move has given the individual access to a new qualified dental plan;

8. An individual is a member of a federally recognized American Indian Indian or Alaska Native Tribe. Individuals may enroll in or change qualified dental plans one time each month;

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

10. An individual demonstrates to Covered California that in accordance with guidelines provided by HHS the individual meets other exceptional circumstances as Covered California may provide.

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

**Coverage Effective Dates**

Coverage effective dates are determined during your application and enrollment with Covered California and
can be affected by any medical policy you purchase. Your Dental Health Services coverage will begin once the enrollment process is complete, premium payment is received, and the effective date is communicated to Dental Health Services by Covered California.

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

Loss of Medi-Cal or Job-Based Coverage:
If you experience of loss of Medi-Cal or job-based coverage, and use a special enrollment period, coverage would begin on the first day of the next month following your plan selection, regardless of the date during the month you select coverage.

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

Newborn and Adoptive Children:
A newborn, or a child placed for adoption is eligible for coverage from the moment of birth or placement. You must apply through Covered California to enroll your new dependent. If enrollment is not completed according to the rules established by Covered California, the new dependent will be effective according to the open enrollment rules established by Covered California.

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

On a Case By Case Basis:

Covered California may start coverage earlier on a case by case basis.

Receiving Dental Care

Upon enrollment, a participating dentist should be selected to provide dental care. You can find a list of Dental Health Services’ Participating Dentists online at www.dentalhealthservices.com/CA or through www.coveredca.com. For a printed directory, call 855-495-0905.

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

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

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

Language and Communication Assistance

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

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

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

Working With Your Dentist

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

Covered services are only provided by participating dentists who are contracted with Dental Health Services.

Dental Health Services values its members and participating dentists. Providing an environment that encourages healthy relationships between members and their dentists helps to ensure the stability and quality of your dental plan.

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

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

Quality Assurance

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

Dentist Access Standards – Primary Care

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

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

Dentist Access Standards – Specialists

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

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

Changing Dental Offices

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

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

Obtaining a Second Opinion

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

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

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

Treatment Authorization

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

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

Authorization, Modification, or Denial of Services

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

• Member eligibility for services.
• Benefits are a covered service of the member’s plan.
• Dentists selected to provide services are in-network or are approved out-of-network providers.
• Status of any applicable maximums.
• Requested submission of necessary clinical documentation.
• Submission of proper procedure coding.
• Accurate submission of referral as explained in the
If Dental Health Services is unable to complete a review within the required time frame, it will immediately, upon the expiration of the require time frame or as soon as the plan become aware that it will not meet the time frame, whichever occurs first, notify the provider and enrollee in writing:

• That it is unable to make the decision within the required time frame because the plan does not have all reasonably necessary information requested or requires an expert consultation or additional examination;

• What specific information has been requested but not received, or any additional examination or test required, or specifying the expert reviewer to be consulted; and

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

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

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

Your Financial Responsibility

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

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

**Covered California - Coordination of Benefits**

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

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

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

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

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

**Out-of-Pocket Maximum**

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

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

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

**Liability of Subscriber for Payment**

You will be liable for the cost of non-covered services performed by a participating dentist and for any services performed by a non-participating dentist that Dental Health Services does not pre-approve or pay. You are not liable for any sums owed by Dental Health Services to a participating dentist.

**IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at 855-495-0905. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.
Optional Treatment

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

Emergency Care: In-Area

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

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

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

Emergency Care: Out-of-Area

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

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

Urgent Care

Urgent care includes conditions that do not necessarily require immediate attention, but should be taken care of as soon as possible, such as lost or cracked fillings, or a broken tooth or crown.

Urgent care situations should be taken care of within 72 hours. If an urgent dental situation occurs, please contact Your Participating Dentist or Member Services at 855-495-0905 for an urgent referral. Prior authorization is not required for urgent services.

Continuity of Care

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

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

**Current Members:** You may request continuation of covered services for certain qualifying conditions from your participating provider in the event that the provider’s contract is terminated. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of qualifying conditions if the services are provided by a dental office that is no longer contracted with Dental Health Services. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered.

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

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

- Completion of covered services for an enrollee who is a newborn child between birth and age 36 months, not to exceed 12 months from the contract termination date for current enrollees or 12 months from the effective date of coverage for a newly covered enrollee;

- Performance of a surgical or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within
180 days of the provider’s contract termination for current enrollees or 180 days from the effective date of coverage for newly covered enrollees.

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

**Termination of Benefits**

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

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

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

- If information contained in the application or otherwise provided to Dental Health Services by the subscriber or member or anyone acting on their behalf, was intentionally or materially incomplete or inaccurate.

- If the subscriber no longer lives or works in the Dental Health Services service area.
• If the subscriber or member is fraudulent or deceptive in obtaining, or attempting to attain, benefits for themselves, or for another person, under this plan.

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

Coverage for the member and his/her dependents will terminate at the end of the month during which the subscriber/member ceases to be eligible for coverage, except for any of the reasons above, when termination may be mid-month. Dental Health Services will issue a Notice of Termination to the subscriber by mail at least 30 days prior to cancelling the coverage.

Termination Due to Nonpayment

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

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

Any service(s) then “in progress” can be completed within the 30-day grace period, with the member’s cooperation. The member is responsible for any scheduled copayments, if any. We encourage you to make individual arrangements with your dentist for continuation of diagnosed services if benefits are terminated.
If you wish to terminate your coverage immediately, contact Member Services at 855-495-0905 as soon as possible.

**Review of Termination**

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

**Termination of Coverage by Enrollee**

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

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

2. Death of the enrollee.

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

**Cancellation Policy**

If subscribers wish to cancel their plan prior to their first year renewal period, they will be subject to a $35.00 cancellation fee to cover the administrative and healthcare costs of the cancellation process. If applicable, any unearned premiums, less any cancellation fees, will be refunded within 30 days.

Subscribers may be required to communicate cancellation requests directly to Covered California. If you wish to cancel your dental benefits, please contact us at 855-495-0905. Cancellation requests must
be received in writing and must be signed by the subscriber.

Cancellation requests received by the 15th of the current month will be effective the first of the following month.

Re-enrollment

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

Grievance Procedure

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

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

You have 180 calendar days following any incident or action that is the subject of your dissatisfaction to file your grievance. Grievances are addressed immediately and responded to in writing within five days. Every effort will be made by Dental Health Services to resolve grievances within 30 business days of receiving the grievance or notification. Urgent grievances are addressed immediately and responded to in writing within 3 calendar days. Should you be unhappy with the decision, you may request a review by notifying Dental Health Services in writing.
Voluntary mediation is available by submitting a request to Dental Health Services. In cases of extreme hardship, Dental Health Services may assume a portion or all of an enrollee’s or subscriber’s share of the fees and expenses of the neutral arbitrator.

If you choose to dispute any eligible dental coverage or procedure that has been denied, modified, or delayed in whole or in part due to a finding that the service is not medically necessary, you may seek a second opinion with the Plan. In cases where a dispute was filed as a formal grievance with Dental Health Services and you disagree with the resolution, you may file a review with the state by contacting the Department of Managed Health Care.

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

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

Confidentiality and Privacy Notice

Dental Health Services is required by law to maintain the privacy and security of your protected health information. This notice describes how your medical and dental information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is updated effective April 1, 2014.

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information that we may obtain or to which we have access. We do not sell our client information. Your personal information will not be disclosed to nonaffiliated third parties, unless permitted or required by law, or authorized in writing by you. Additionally, Dental Health Services will not use your member information for marketing purposes.

Throughout this Notice, unless otherwise stated, your medical and dental health information refers to only health information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional circumstances.

Dental Health Services’ privacy policies describe who has access to your PHI within the organization, how it will be used, when your PHI may be disclosed, safeguards to protect the privacy of your PHI and the training we provide our employees regarding maintaining
Under what circumstances must Dental Health Services share my PHI?

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

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

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

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

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

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

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

  • preventing or reducing a serious threat to the public’s health or safety;
  • concerning victims of abuse, neglect or domestic violence;
  • health oversight agency;
  • judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you;
  • law enforcement purposes, subject to subpoena or law;
  • Workers’ Compensation purposes;
  • parents or guardians of a minor; and
  • persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has received contractual assurances to protect the privacy of your PHI.

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

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

**Does my employer have the right to access my PHI?**

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

- you sign an authorization for release of your medi-
cal/dental information; or

- health care services were provided with specific pri-
or written request and expense of the employer, and
are relevant in a grievance, arbitration or lawsuit, or
describe limitations entitling you to leave from work
or limit work performance.

Any such disclosure is subject to Dental Health Ser-
vices’ “minimum necessary” disclosures policy.

**What is Dental Health Services’ “Minimum
Necessary” Policy?**

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

- your dentist for treatment purposes;

- you; or

- disclosures covered by an authorization you pro-
vided to another entity.

**What are my rights regarding the privacy of
my PHI?**

- You may request Dental Health Services to restrict
uses and disclosures of your PHI in the performance of its payment or health care operations. However, a written request is required. Your health is the top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your requested restriction, the restriction will not apply in situations involving emergency treatment by a health care provider.

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

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

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

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

- You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to 6 years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:
  - disclosures made for payment or health care operations
Your request must be made in writing. Dental Health Services will provide the accounting within 60 days of your request but may extend the period for up to an additional 30 days. The first accounting requested during any 12-month period will be made without charge. There is a $25 charge for each additional accounting requested during such 12-month period. You may withdraw or modify any additional requests within 30 days of the initial request in order to avoid or reduce the fee.

You have the right to receive a copy of this Notice, and any amended Privacy Notice, upon written or telephone request made to Dental Health Services.

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

• personal delivery;
• email delivery to: membercare@dentalhealthservices.com;
• first class or certified U.S. Mail; or
• overnight or courier delivery, charges prepaid

What duties does Dental Health Services agree to perform?

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

• Dental Health Services will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• Dental Health Services will abide by the terms of this Notice and any revised Notice, during the period that it is in effect.
• Dental Health Services reserves the right to change the terms of this Notice or any revised notice. Any new terms shall be effective for all PHI that
it maintains including PHI created or received by Dental Health Services prior to the effective date of the new terms. Each time Dental Health Services makes a revised Notice, it shall 1) post it on its website, www.dentalhealthservices.com and 2) distribute a written copy personally by First Class U.S. Mail to each of its subscribers who are enrolled with Dental Health Services during the period that such revised Notice remains effective.

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

You have the right to express your dissatisfaction or objection to Dental Health Services and to the Secretary of HHS if you believe your privacy rights have been violated. You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington DC, 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Grievances to Dental Health Services must be made in writing to Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807 Attn: Privacy Officer. Your written dissatisfaction must describe the acts or omissions you believe to be in violation of the provisions of this Notice or applicable laws. Your written objection to HHS or Dental Health Services must be filed within 180 days of when you knew or should have known of the act or omission. You will not be penalized or retaliated against for communicating your dissatisfaction. We are eager to assist you.

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

You may obtain further information regarding your PHI privacy rights by contacting your Dental Health Services Member Service Specialist at 855-495-0905 during regular office hours or through www.dentalhealthservices.com.
Public Policy Committee

As a member of Dental Health Services, your concerns about benefits and services that Dental Health Services offers are important to us. Dental Health Services’ Public Policy Committee reviews member needs and concerns, and recommends improvements to the Plan. You are invited to participate in the Public Policy Committee. If you are interested in membership of the committee or would like to comment, send your request in writing to the Public Policy Committee Coordinator, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807-3505.

Organ Donation

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

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

Spanish


Dental Health Services

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

An Employee-Owned Company