Dental Net®

3000D

Combined Evidence of Coverage and Disclosure Form

This Evidence of Coverage (EOC) contains the exact terms and conditions of coverage. Please read the disclosure and the EOC completely and carefully. Individuals with special dental care needs should carefully read those sections that apply to them.

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367
1 (800) 627-0004

PROFESSIONAL PLASTICS, INC.

Welcome to Dental Net®

This booklet is your Evidence of Coverage. It explains what your plan covers and does not cover. You have a right to review this Evidence of Coverage prior to enrollment. You may obtain a copy by requesting it from your group or by writing to Anthem Blue Cross 21555 Oxnard Street, Woodland Hills, California 91367, or by calling 1 (800) 627-0004.

Within this booklet, members are referred to as "you" or "your". Anthem Blue Cross is referred to as "we", "us" or "our". All italicized words are defined in the **DEFINITIONS** section of this booklet.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

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How to Use Dental Net®

Dental Net is a dental program that you get through a group, such as an employer. It consists of a network of dental offices and dental professionals who have contracted with us to provide you with the wide range of dental services for which you are entitled to under this *plan*. From these many providers, you choose the dental office that will thereafter provide your dental care. Even if you have belonged to a dental program before, take some time to learn about Dental Net. This chapter tells you about your Dental Net plan and how to use it.

How to Contact Us

We are here to help you. Call us if:

- You have a question or problem.
- You need a new *dentist*.
- You need to replace your ID card.

☎ 1 (800) 627-0004
✉ Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, California 91367
🖱 www.anthem.com/ca

When you visit our website, click on the "Health and Wellness" link for information on dental care and more.

Your ID Card

Your ID card shows your *dentist* what plan you are on. You will need your ID card each time you see the *dentist*. Keep your ID card with you and present it when asked.

The Dental Net Service Area

The service area is the geographical area in which we have a panel of selected general dentists and *specialists* who have agreed to provide care to Dental Net members. To enroll in the Dental Net plan, you must reside, live, or work in the service area.

Dentists and Other Providers

Dental Net has a network that includes many general *dentist*s and dental *specialists*. Your primary general *dentist* coordinates most of your care. Your primary general *dentist* may refer you to a dental *specialist* for specialty dental care.

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

Choice of Dentists

When you enroll in the Dental Net plan, you must choose a *participating dental office* from our Dental Net network. You must get all your dental care from your selected *participating dental office*, unless you get emergency care or we pre-approve on an exception basis, a visit to a dentist who is not in our network.

Pediatric Referral for Children

If you have a dependent child or children under age seven 7, you may select a Pedodontist (a *dentist* that specializes in treating children) for their dental care. Dependent children are eligible for a standing Pediatric referral to age seven (7). This means Dental Services can be performed until the end of the month in which the Dependent child reaches age seven (7). Upon attaining age seven (7), the Dependent child must receive their dental care from a selected *participating dental office* unless referral to a Pedodontist is required for continued dental care.

How to Change Dentist Offices

You may transfer from one *participating dental office* to another. To do this, you must call us or write to us. We must receive your request by the 15th of the month to make a change for the following month.

☏ 1 (800) 627-0004
✉ Anthem Blue Cross, PO Box 659444, San Antonio, Texas 78265

We must approve your request for it to become effective.

Note: If you are in the process of getting a dental procedure that involves multiple visits, all of the services must be completed by the same dental office.

Your dental office may also request you to be transferred. The request will be considered based upon the nature of the request. See the section **WHO IS COVERED AND WHEN: HOW COVERAGE ENDS** for more information.

Facilities and Provider Directories

A complete list of *participating dental offices* can be found on our website.

- www.anthem.com/ca

Once you're on the website, click on Menu and then Find a Doctor. You can search as a Member in this online *participating dental office*/ dental provider directory using your Anthem ID card to make sure you find a Participating Dentist who accepts your *plan*. Besides listing the dental providers located in the area you have requested along with their office telephone number, the website provides the driving distance and directions to the office location.

You can also call our Customer Department at the telephone number listed on your Identification Card, which is (800) 627-0004 for assistance. Please note that we have several networks and that a provider who participates for one plan may not participate for another. Be sure to check your Identification Card or call our Customer Service Department to find out which network this Plan uses.

How to Get Care When You Need It

Your primary care *dentist* is the first person you should consult for dental care. He or she is responsible for providing you with dental care and determining when you need a referral for specialist care.

Making an Appointment

To see your primary care *dentist* you will need to call and make an appointment. When you call, identify yourself as a Dental Net member and have the following information from your ID card available:

- Your name.
- The certificate number on your ID card.
- The group number from your ID card.
- The name of your *dentist*.
- A brief explanation of your symptoms, if any.

It is important to bring your ID card with you to your appointment, as the dental office will ask to see your ID card. You must have this card to receive your Dental Net benefits.

Your first visit to your primary care *dentist* will usually consist of x-rays and an examination only. By performing these procedures first, your primary care *dentist* can establish your treatment plan according to your overall dental needs.

If you are not able to keep your appointment, call the dental office as soon as possible to let them know. Your dental office may charge you if you do not cancel your appointment at least twenty-four (24) hours before your appointment. These charges will not be paid by us. You will be responsible to pay for any charges for missed appointments.

Timely Access to Care

Anthem has contracted with participating dentists to provide covered services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its network of participating dentists have the capacity and availability to offer appointments within the following timeframes:

- Urgent care appointments: within 72 hours of the request for an appointment;
- Non-urgent appointments for primary care: within 36 business days of the request for an appointment; and
- Preventive dental care appointments: within 40 business days of the request for an appointment.

If a participating dentist determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the participating dentist may schedule an appointment for a later time than noted above.

Participating dentists are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain urgent or emergency care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of your appointment.

Second Opinions

There may be times when you want a second opinion on your dental condition or treatment. Some reasons to get a second opinion include but are not limited to:

- You have questions about your dental condition or the treatment your primary care *dentist* prescribed;
- You have a concern about the quality of care given by your *dentist*; or
- Your *dentist* is unable to treat your condition, or current treatment is not improving your condition.

To get a second opinion, you must first contact us for approval. To request approval for a second opinion, call or write to us at:

☏ 1 (800) 627-0004
✉ Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, California 91367

Upon request for a second opinion, we will provide an authorization or denial within 72 hours after Anthem's receipt of the request.

If approved, you can get a second opinion through another *dentist* within the Dental Net network. Your second opinion will include a consultation only. No treatment will be given at that time. You do not have to pay extra charges for a second opinion. You are only responsible to pay any applicable *copayments* for the consultation. Contact us if you need help selecting a *dentist* for your second opinion.

We will authorize a consultation for a second opinion by a Non-Participating Dentist if a Participating Dentist is not available. You are only responsible to pay any applicable *copayment* for the consultation and Anthem will pay the difference of the Non-Participating Dentist's consultation fee. If your request is denied, you can appeal the decision through our grievance procedures. See the section **GRIEVANCE PROCEDURES** for more information.

Referral for Specialty Care

In the course of dental treatment, you may need the care of a dental *specialist*. If this happens, your assigned primary care *dentist* is able to refer you directly to a dental *specialist*. If you would like an estimate of your out of pocket costs for the referral, your primary care *dentist* can submit a request to us for a referral for specialty care. If approved, we will send a notice to you within five days of the request with the following information:

- The services that have been approved;
- The name and phone number of *specialists* that will provide the services;
- The time frame in which you have to receive the services; and
- Any *copayment* amounts that you will need to pay for the services.

Remember, only dental services that qualify for direct referral by your primary care *dentist* or approved by us will be covered.

Our payments for specialty care will be subject to the exclusions, limitations, and benefit maximums of your *plan*.

Emergency Care

Emergency care is dental services provided for the treatment or alleviation of severe pain, uncontrollable bleeding, or swelling. All *dentists* in the Dental Net network are available for emergency care twenty-four hours a day, seven days a week. If possible, you should get emergency care from your primary care *dentist*. If it is not possible to get emergency care from your primary care *dentist*, you may go to any dentist, or go to the closest emergency room. Prior approval for emergency care is not required.

If you require emergency care more than 35 miles from your *dentist*, you may get care from any dentist. You will be responsible to pay for the emergency care. You should contact us as soon as you are able after receiving the emergency care, as we will tell you how to submit your receipt to us for reimbursement. We will reimburse you up to $100 towards the cost of an emergency exam, palliative care and x-rays, less any applicable *copayment*s. Our payments for emergency care will be subject to the exclusions, limitations, and benefit maximums of your *plan*.

Your Financial Responsibility

Prepayment Fee

Your employer is responsible for paying the charges for your coverage. Your employer may require you to pay a portion of the charges. If this is the case, your employer will tell you the amount and how it is to be paid. The exact charge for coverage is included in the *agreement* between your employer and us. You can obtain a copy of the *agreement* through your employer or by contacting us.

Copayments

A *copayment* is the amount you will pay for a dental care service. *Copayments* will be due at the time you receive a service. You are not required to submit a claim for dental care received from your *dentist*. Your *copayment* amounts are listed under **WHAT IS COVERED: SCHEDULE OF COPAYMENTS**.

Office Visit Fee

Every time you visit your *participating dental office*, you are responsible to pay an office visit fee, whether dental services are or are not performed. The fee is $5 per visit and is payable directly to the *participating dental office*. This fee is in addition to your *copayment* for all other dental services. Office visit fees do not apply to visits to a *specialist*.

Other Charges

If you change your dental office, you may have to pay reasonable costs for the copy and transfer of your dental records and x-rays to the new office.

Continuity of Care

Termination of Dental Office

If your primary care *dentist's* contract with us terminates, there are situations in which you may still be able to receive dental care from them that is covered under this *plan*. This provision, however, will not apply if the primary care *dentist*'s contract is terminated for reasons of medical disciplinary reasons, fraud, or other criminal activity.

In order to continue receiving covered dental care, the *dentist* must agree in writing to continue providing care to you under the same terms and conditions of the contract with us before it was terminated. If the *dentist* does not agree, we do not have to continue coverage beyond their contract termination date.

Transition Assistance

In certain situations, new *members* to this *plan* may be able to complete their dental care with a dentist outside of our Dental Net network. We will ask the dentist to accept the terms and conditions of the current contract we have with our Dental Net *dentists*. If the dentist does not agree to our terms and conditions, we are not required to cover the completion of your care with them.

If you would like to request continuity of care or to obtain a copy of the written policy for continuity of care, please contact us at:

☏ 1 (800) 627-0004

What is Covered

The following is a brief overview of the types of dental care that is covered under this *plan*. For a more detailed listing, see the **SCHEDULE OF COPAYMENTS** later in this section.

Specialty Dental Care

Your *plan* includes specialty services given by endodontists, periodontists, oral surgeons and pediatric *dentist*s. Your *plan* does not cover services given by a prosthodontist.

Types of Services

Diagnostic Services. These are services that are used to evaluate your dental condition and determine the type of dental care you may need.

Preventive Services. These services are given to help prevent certain dental conditions.

Restorative Services. These services are performed to restore tooth structure lost as a result of dental decay.

Endodontic Services. These services are given to treat the nerve or pulp of the tooth that has been injured or infected.

Periodontic Services. These services are given to treat the supporting structures of the teeth, such as gums or underlying bone.

Prosthodontics (Removable and Fixed). These services are given to restore and/or replace missing teeth with artificial substitutes.

Implant Supported Services. These services are related to dental implants, which are artificial teeth anchored in the gums or jawbone to replace a missing tooth.

Oral Surgery Services. These are surgical services to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics Services. These services are used to straighten the teeth through the use of braces. See the section **ORTHODONTIC SERVICES** for more information on coverage for orthodontic services.

Adjunctive General Services. These are various miscellaneous dental services.

Enhanced Dental Services. Additional preventive and periodontal services due to medical necessity.

Schedule of Copayments

This is a list of dental care services that are covered by this *plan* and includes your *copayment* amount and limitations for those services. We will not cover dental care services that are not listed in this section. See **DENTAL TERMINOLOGY** at the end of this section to help you understand some of the common terms used in this schedule. All services are subject to conditions, terms, limits, and exclusions of the *plan*. You should read your entire Evidence of Coverage and Disclosure Form to better understand your benefits under this *plan*.

In order for services to be covered under this *plan*, all services must be authorized by your primary care *dentist* or by us. Services received from a dentist outside of the Dental Net network are NOT covered under this *plan*.

IMPORTANT: If you decide to get dental care services that are not covered under this *plan*, your Dental Net primary care *dentist* may charge you their usual rate for those services. Before the primary care *dentist* performs services that are not covered, they should give you a treatment plan that tells you what services are to be performed and the estimated cost of each service. If you would like more information about your dental coverage options, call us at 1 (800) 627-0004. To fully understand your coverage, you should carefully review this Evidence of Coverage and Disclosure Form.

Your primary care *dentist* is responsible for coordinating your dental care. In the course of dental treatment, you may need the care of a *dental specialist*. If this happens, your primary care *dentist* is able to refer you directly to a *dental specialist*. See the section **REFERRAL FOR SPECIALTY CARE** earlier in this booklet for more information.

Diagnostic Services

Clinical Oral Evaluations

- **Oral evaluation for a patient under three years of age** and counseling with a primary caregiver is covered two (2) times per twelve (12) month period.

- **Periodic, Comprehensive, Oral, and Periodontal Evaluation(s) or Consultation**. Limited to two (2) times per twelve (12) month period.

- **Limited, Detailed/Extensive, Problem Focused Evaluation(s)**. Limited to two (2) times per twelve (12) month period.

Code	Description	Copayment
D0120	**Periodic oral evaluation** – established patient	$0

D0140 **Limited oral evaluation** – problem focused $0
D0145 **Oral evaluation for a patient under three years of age** $0
D0150 **Comprehensive oral evaluation** – new or established patient $0
D0160 **Detailed and extensive oral evaluation** – problem focused, by report $0
D0170 **Re-evaluation – limited, problem focused** (established patient; not post-operative visit) $0
D0171 **Re-evaluation - post-operative office visit** $0
D0180 **Comprehensive periodontal evaluation** – new or established patient $0
D0190 **Screening of a patient** $0
D0191 **Assessment of a patient** $0

Radiographs/Diagnostic Imaging (Including Interpretation)

- **Panoramic Radiograph** or **Full Mouth X-rays** are limited to one (1) time per thirty-six (36) month period unless medically necessary for a specific dental problem.

- **Extraoral x-rays** (posterior images) **in combination with bitewing x-rays.** Covered two (2) series per twelve (12) month period. The dental codes included in combination with extraoral x-rays are D0270, D0272, D0273, D0274 and D0277.

- **Bitewings** (**including vertical bitewings**). Benefit is two (2) series of bitewings per twelve (12) month period. Included in this explanation for frequency are the following dental codes: D0251, D0270, D0272, D0273, D0274 and D0277.

Code	Description	Copayment
D0210	**Intraoral – complete series** (including bitewings)	$0
D0220	**Intraoral – periapical first film**	$0
D0230	**Intraoral – periapical each additional film**	$0
D0240	**Intraoral – occlusal film**	$0
D0250	**Extraoral – first film** inclusive with orthodontic records only	$0
D0251	**Extraoral – posterior dental x-ray images**	$0
D0270	**Bitewing – single film**	$0
D0272	**Bitewings – two films**	$0
D0273	**Bitewings – three films**	$0
D0274	**Bitewings – four films**	$0
D0277	**Vertical bitewings – 7 to 8 films**	$0
D0330	**Panoramic film**	$0
D0391	**Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report**	$0

Tests and Examinations

- **Pulp Vitality Tests** are limited to being performed prior to root canal therapy and not on the same day as treatment root canal therapy.

Code	Description	Copayment
D0415	**Collection of microorganisms for culture and sensitivity**	$0
D0425	**Caries susceptibility tests**	$0
D0431	**Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities**	$0
D0460	**Pulp vitality tests**	$0
D0470	**Diagnostic casts**	$0
D0472	**Accession of tissue, gross examination, preparation and transmission of written report**	$0
D0473	**Accession of tissue, gross and microscopic examination, preparation and transmission of written report**	$0
D0474	**Accession of tissue, gross and microscopic examination**, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	**Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report**	$0
D0486	**Accession of transepithelial cytologic sample, microscopic examination**, preparation and transmission of written report	$0
D0502	**Other oral pathology procedures**, by report	$0
D0601	**Caries risk assessment and documentation, with a finding of low risk**	$0
D0602	**Caries risk assessment and documentation, with a finding of moderate risk**	$0
D0603	**Caries risk assessment and documentation, with finding of high risk**	$0
D0999	**Unspecified diagnostic procedure, by report** - includes office visit, per visit (in addition to other services)	$0

Preventive Services

- **Prophylaxis** (teeth cleaning) for adult and child in combination with **Periodontal Maintenance** - Any combination of these procedures is limited to two (2) times per twelve (12) month period. Additional teeth cleaning and/or periodontal maintenance beyond this benefit frequency is covered at the additional copayment listed below.

- **Sealants** or **Preventive Resin Restorations** per tooth. Any combination of these procedures are limited to one (1) time per thirty-six (36) month period for permanent unrestored first and second molars through age eighteen (18), unless determined to be medically necessaryby your primary care dentist.

- **Topical Application of Fluoride and Topical Application Fluoride Varnish** are limited to two (2) times per thirty-six (36) month period through age eighteen (18), unless determined to be medically necessary by your primary care dentist and then the same copayment would apply. Otherwise an additional topical application of fluoride or topical application of fluoride varnish beyond this benefit frequency is covered at the additional copayment listed below.

- **Space maintainers** - Limited to one (1) time per lifetime, posterior teeth only, through age eighteen (18), unless determined to be medically necessary by your primary care dentist.

Code	Description	Copayment
D1110	**Prophylaxis (teeth cleaning) – adult**	$0
	Additional Prophylaxis (teeth cleaning) – adult	$45
D1120	**Prophylaxis (teeth cleaning) – child**	$0
	Additional Prophylaxis (teeth cleaning) – child	$35
D1206	**Topical Fluoride Varnish; therapeutic application for moderate to high caries risk patients**	$0
	Additional application of Topical Fluoride Varnish	$15
D1208	**Topical application of fluoride-excluding varnish**	$0
	Additional Topical Application of Fluoride – excluding varnish	$15
D1310	**Nutritional counseling for control of dental disease**	$0
D1320	**Tobacco counseling for the control and prevention of oral disease**	$0
D1330	**Oral hygiene instructions**	$0
D1351	**Sealant – per tooth**	$0
D1352	**Preventive resin restoration** – permanent tooth	$10
D1353	**Sealant repair per tooth**	$0
D1354	**Interim decay arresting medicament application, per tooth**	$15
D1510	**Space maintainer – fixed – unilateral**	$35
D1515	**Space maintainer – fixed – bilateral**	$35
D1520	**Space Maintainer- removable unilateral**	$35
D1525	**Space maintainer – removable – bilateral**	$35
D1550	**Re-cementation or rebond space maintainer**	$0
D1555	**Removal of fixed space maintainer**	$10
D1575	**Distal shoe space maintainer, fixed unilateral**	$35
D1999	**Unspecified preventive procedure, by report**	$0

Restorative Services

Code	Description	Copayment
D2140	**Amalgam – one surface, primary or permanent**	$5
D2150	**Amalgam – two surfaces, primary or permanent**	$10

D2160 **Amalgam – three surfaces, primary or permanent** $15
D2161 **Amalgam – four or more surfaces, primary or permanent** $20
D2330 **Resin-based composite – one surface, anterior** $20
D2331 **Resin-based composite – two surfaces, anterior** $25
D2332 **Resin-based composite – three surfaces, anterior** $25
D2335 **Resin-based composite – four or more surfaces or involving incisal angle (anterior)** . $40
D2390 **Resin-based composite crown, anterior** $50
D2391 **Resin-based composite – one surface, posterior** $65
D2392 **Resin-based composite – two surfaces, posterior** $75
D2393 **Resin-based composite – three surfaces, posterior** $85
D2394 **Resin-based composite – four or more surfaces, posterior** $95

Crowns – per unit/tooth

- There is an additional charge of $125 that applies for any procedure using noble, high noble, titanium metals and porcelain on molar teeth. This is in addition to the listed *copayment*.

- An additional charge not to exceed $125 applies per tooth/unit involving six (6) or more crowns, veneers, implant bridge pontics/inlays/onlays and abutements if these procedures are included in the same treatment plan.

- **Crowns** are limited to once per tooth per sixty (60) month period.

- **Prefabricated and Stainless Steel Crowns.** Covered one (1) time per tooth per sixty (60) month period.

- **Core Buildup**, **including any pins when required** is limited to one (1) time per tooth per sixty (60) month period.

- **Pin retention** - per tooth, in addition to restoration is limited to one (1) time per sixty (60) month period.

- **Prefabricated post and core in addition to crown** is limited to one (1) time per tooth per sixty (60) month period.

- **Labial veneers** (laboratory and chairside) are limited to one (1) per tooth per sixty (60) month period.

Code	Description	Copayment
D2410	**Gold foil – one surface**	$85
D2420	**Gold foil – two surfaces**	$130

D2430 **Gold foil – three surfaces** $320
D2510 **Inlay – metallic – one surface** $140
D2520 **Inlay – metallic – two surfaces** $150
D2530 **Inlay – metallic – three or more surfaces** $160
D2542 **Onlay – metallic – two surfaces** $160
D2543 **Onlay – metallic – three surfaces** $165
D2544 **Onlay – metallic – four or more surfaces** $175
D2610 **Inlay – porcelain/ceramic – one surface** $170
D2620 **Inlay – porcelain/ceramic – two surfaces** $180
D2630 **Inlay – porcelain/ceramic – three or more surfaces** $190
D2642 **Onlay – porcelain/ceramic – two surfaces** $175
D2643 **Onlay – porcelain/ceramic – three surfaces** $185
D2644 **Onlay – porcelain/ceramic – four or more surfaces** $195
D2650 **Inlay – resin-based composite – one surface** $105
D2651 **Inlay – resin-based composite – two surfaces** $120
D2652 **Inlay – resin-based composite – three or more surfaces** $145
D2662 **Onlay – resin-based composite – two surfaces** $140
D2663 **Onlay – resin-based composite – three surfaces** $150
D2664 **Onlay – resin-based composite – four or more surfaces** $160
D2710 **Crown – resin-based composite (indirect)** $55
D2712 **Crown – ¾ resin-based composite (indirect)** $55
D2720 **Crown – resin with high noble metal** $170
D2721 **Crown – resin with predominantly base metal** $85
D2722 **Crown – resin with noble metal** $135
D2740 **Crown – porcelain/ceramic substrate** $235
D2750 **Crown – porcelain fused to high noble metal** $225
D2751 **Crown – porcelain fused to predominantly base metal** $135
D2752 **Crown – porcelain fused to noble metal** $190
D2780 **Crown – ¾ cast high noble metal** $190
D2781 **Crown – ¾ cast predominantly base metal** $110
D2782 **Crown – ¾ cast noble metal** $140
D2783 **Crown – ¾ porcelain/ceramic** $215
D2790 **Crown – full cast high noble metal** $200
D2791 **Crown – full cast predominantly base metal** $120
D2792 **Crown – full cast noble metal** $150
D2794 **Crown – titanium** $240
D2799 **Provisional crown** $60
D2910 **Recement inlay, onlay, or partial coverage restoration** $10
D2915 **Recement cast or prefabricated post and core** $10
D2920 **Recement crown** $10
D2921 **Reattachment of tooth fragment, incisal edge** $10
D2929 **Prefabricated porcelain/ceramic crown** $75
D2930 **Prefabricated stainless steel crown – primary tooth** $50
D2931 **Prefabricated stainless steel crown – permanent tooth** $50

D2932 **Prefabricated resin crown** $65
D2933 **Prefabricated stainless steel crown with resin window** $60
D2934 **Prefabricated esthetic coated stainless steel crown – primary tooth** $60
D2940 **Protective restoration (sedative filling)** $10
D2941 **Interim therapeutic restoration, primary tooth** $10
D2949 **Restorative foundation for an indirect restoration** $15
D2950 **Core buildup, including any pins** $50
D2951 **Pin retention – per tooth, in addition to restoration** $15
D2952 **Post and core in addition to crown, indirectly fabricated** $50
D2953 **Each additional indirectly fabricated post** – same tooth $25
D2954 **Prefabricated post and core** in addition to crown $60
D2955 **Post removal** (not in conjunction with endodontic therapy) $20
D2957 **Each additional prefabricated post** – same tooth $15
D2960 **Labial veneer** (resin laminate) – **chairside** $125
D2961 **Labial veneer** (resin laminate) – **laboratory** $340
D2962 **Labial veneer** (porcelain laminate) – **laboratory** $390
D2971 Additional procedures to **construct new crown under existing partial denture framework** $50
D2980 **Crown repair**, by report $15
D2981 **Inlay repair** $15
D2982 **Onlay repair** $15
D2983 **Veneer repair** $15
D2990 **Resin infiltration of incipient smooth surface lesion** $10
D2999 **Unspecified restorative procedure** $0

Endodontic Services

- The *copayments* listed for endodontic procedures do not include the cost of the final restoration.
- **Root canal treatments -** limited to once per permanent tooth.
- **Root canal retreatments** are limited to once per tooth per lifetime.
- **Pulp capping** (**direct or indirect**) is limited to one (1) time per tooth per lifetime.
- **Pulpal therapy** is limited to once per primary tooth per lifetime.
- **Pulpal debridement** is limited to once per primary and permanent tooth per lifetime.
- **Apicoectomies**, first root and each additional root are limited to premolars and molars once per lifetime for permanent teeth only.

- **Hemisection**. Covered once per tooth per lifetime.

- **Bone grafts in conjunction with periradicular surgery** per tooth, and each additional contiguous tooth in the same surgical site are limited to once per site or tooth per thirty- six (36) month period.

- **Treatment of root canal obstruction**, non-surgical, is limited to one time per tooth per lifetime.

- **Incomplete endodontic therapy** for an inoperable or unrestorable or fractured tooth is limited to once per tooth per lifetime.

- **Internal root repair of perforation defects** is limited to once per tooth per lifetime.

- **Periradicular surgery without apicoectomy** is covered once per tooth per lifetime.

- **Partial pulpotomy for apexogenesis**; permanent tooth with incomplete root development is limited to once per tooth per lifetime.

- **Surgical procedure for isolation of tooth** with rubber dam is limited to once per tooth per lifetime.

- **Canal preparation and fitting of performed dowel or post** is limited to once per tooth per lifetime.
- **Apexification/recalcification** - initial visit, interim medication replacement and final visit are each limited to once per tooth per lifetime.

- **Pulpal regeneration** - initial visit, interim medication replacement, and completion of treatment are each limited to once per tooth per lifetime.

- **Canal preparation and fitting of preformed dowel or post -** Covered once per tooth per lifetime.

The following endodontic services beginning at code D3110 to code D3357 direct pulp capping to retreatment of previous root canal (molar) are limited to once per tooth per lifetime.

Code	Description	Copayment
D3110	**Pulp cap – direct** (excluding final restoration)	$0
D3120	**Pulp cap – indirect** (excluding final restoration)	$0
D3220	**Therapeutic pulpotomy** (excluding final restoration) –	$25
D3221	**Pulpal debridement**, primary and permanent teeth	$30
D3222	**Partial pulpotomy for apexogenesis** –	$25

D3230 **Pulpal therapy** (resorbable filling) – anterior, primary tooth (excluding final restoration) $40
D3240 **Pulpal therapy** (resorbable filling) – posterior, primary tooth (excluding final restoration) $40
D3310 **Endodontic therapy, anterior tooth** (excluding final restoration) $90
D3320 **Endodontic therapy, bicuspid tooth** (excluding final restoration) $140
D3330 **Endodontic therapy, molar** (excluding final restoration) $225
D3331 **Treatment of root canal obstruction**; non-surgical access $70
D3332 **Incomplete endodontic therapy**; inoperable, unrestorable or fractured tooth $70
D3333 **Internal root repair of perforation defects** $70
D3346 **Retreatment of previous root canal therapy – anterior** $100
D3347 **Retreatment of previous root canal therapy – bicuspid** $150
D3348 **Retreatment of previous root canal therapy – molar** $245
D3351 **Apexification/recalcification – initial visit** (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) $75
D3352 **Apexification/recalcification – interim medication replacement** (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) .. $50
D3353 **Apexification/recalcification – final visit** (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) $50
D3355 **Pulpal regeneration- initial visit** $85
D3356 **Pulpal regeneration - interim medication replacement** $45
D3357 **Pulpal regeneration - completion of treatment** $85
D3410 **Apicoectomy/periradicular surgery – anterior** $90
D3421 **Apicoectomy/periradicular surgery – bicuspid (first root)** $100
D3425 **Apicoectomy/periradicular surgery – molar (first root)** $110
D3426 **Apicoectomy/periradicular surgery (each additional root)** $65
D3427 **Periradicular surgery without apicoectomy** $75
D3428 **Bone graft in conjunction with periradicular surgery - per tooth, single site** $200
D3429 **Bone graft in conjunction with periradicular surgery- each additional contiguous tooth** in same surgical site $115
D3430 **Retrograde filling – per root** $55
D3450 **Root amputation –** per root $85
D3910 **Surgical procedure for isolation of tooth with rubber dam** $15
D3920 **Hemisection** (including any root removal), not including root canal therapy $110
D3950 **Canal preparation and fitting of preformed dowel or post** $15
D3999 **Unspecified endodontic procedure- by report** $0

Periodontic Services

- The following surgical periodontal procedures are limited to once per quadrant per thirty - six (36) month period:
    - **Gingivectomy or Gingivoplasty;**

- **Gingival Flap Procedures;**
- **Osseous Surgery;** and
- **Bone Replacement Grafts;**

- The following surgical periodontal procedures are limited to once per tooth site per thirty-six (36) month period:
  - **Guided Tissue Regeneration;**
  - **Apically Positioned Flap;**
  - **Pedicle Soft Tissue Graft;**
  - **Soft Tissue Allograft;**
  - **Autogenous Connective Tissue Grafts;**
  - **Mesial/Distal Wedge Procedure** - natural teeth only**;**
  - **Non-Autogenous Connective Tissue Graft;**
  - **Free Soft Tissue Grafts;** and
  - **Subepithelial Connective Tissue Graft.**

- **Periodontal scaling and root planing** is limited to one (1) time per quadrant site per twenty four (24) month period.

- **Periodontal maintenance procedure** in combination with routine prophylaxis is limited to two (2) times per twelve (12) month period. An additional periodontal maintenance procedure beyond the benefit frequency is covered at the additional copayment listed below.

- **Full mouth debridement** is limited to one (1) time per lifetime.

- **Crown lengthening**. Covered when there is no other restorative treatment being performed on the same day.
- **Provisional splinting** - intracoronal and extracoronal are limited to once per tooth/area per thirty-six (36) months.

- **Scaling in presence of generalized moderate or severe gingival inflammation** is limited to two (2) times per twelve (12) month period.

- **Localized delivery of antimicrobial agents** via a controlled release vehicle is limited to once per tooth per site per twelve (12) months to a maximum of six (6) teeth per twelve (12) months with prior history of gingival flap procedures, root planning and scaling procedures or previous localized delivery of antimicrobial agents.

- **Gingival irrigation** is limited to once per quadrant per thirty-six (36) months.

Code	Description	Copayment
D4210	**Gingivectomy or gingivoplasty** – four or more contiguous teeth or tooth bounded spaces per quadrant	$130
D4211	**Gingivectomy or gingivoplasty** – one to three contiguous teeth or tooth bounded spaces per quadrant	$75
D4212	**Gingivectomy or gingivoplasty** to allow access	$80
D4240	**Gingival flap procedure**, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$130
D4241	**Gingival flap procedure**, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$75
D4245	**Apically positioned flap**	$125
D4249	**Clinical crown lengthening** – hard tissue	$120
D4260	**Osseous surgery** (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$275
D4261	**Osseous surgery** (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$220
D4263	**Bone replacement graft – first site in quadrant**	$210
D4264	**Bone replacement graft – each additional site in quadrant**	$105
D4265	**Biologic materials to aid in soft and osseous tissue regeneration**	$135
D4266	**Guided tissue regeneration – resorbable barrier**, per site	$175
D4267	**Guided tissue regeneration – non-resorbable barrier**, per site (includes membrane removal)	$205
D4270	**Pedicle soft tissue graft procedure**	$205
D4273	**Subepithelial connective tissue graft procedures**, per tooth	$90
D4274	**Distal or proximal wedge procedure** (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4275	**Soft tissue allograft**	$415
D4277	**Free soft tissue graft, first tooth, implant or tooth position**	$245
D4278	**Free soft tissue graft, each additional tooth, implant or tooth position**	$245
D4283	**Autogenous connective tissue graft**	$345
D4285	**Non-autogenous connective tissue graft**	$345
D4320	**Provisional splinting – intracoronal**	$105
D4321	**Provisional splinting – extracoronal**	$95
D4341	**Periodontal scaling and root planing – four or more teeth per quadrant**	$45
D4342	**Periodontal scaling and root planing – one to three teeth per quadrant**	$35
D4346	**Scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation**	$10
D4355	**Full mouth debridement to enable comprehensive evaluation and diagnosis**	$45
D4381	**Localized delivery of antimicrobial agents** via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$55
D4910	**Periodontal maintenance**	$30
	Additional Periodontal Maintenance procedure	$55
D4920	**Unscheduled dressing change** (by someone other than treating dentist)	$10
D4921	**Gingival irrigation – quadrant**	$10

D4999 **Unspecified periodontal procedure, by report** $0

Prosthodontic Services (Removable)

- There is a charge of $125 when using noble or high noble (precious) metals. This is in addition to your *copayment*.
- There is a $125 charge in addition to your *copayment* for porcelain to metal crowns placed on molars.
- **Complete and Immediate Dentures** are limited to one (1) time per sixty (60) month period. Benefit is for immediate or complete dentures but not both. The denture provided first is the covered dental service.
- **Removable partial dentures, including immediate partial dentures**, are limited to one (1) time per sixty month period.
- **Adjustments for dentures (complete and partial)** are covered when a six (6) month period has passed following initial placement.
- **Denture relines and rebases** are each limited to one (1) time per twelve (12) month period.
- **Precision attachment** is limited to one (1) time per sixty (60) month period.
- **Interim complete and partial dentures,** Limited to one (1) time per sixty (60) month period.
- **Overdentures for upper and lower complete and partial dentures** are limited to one (1) time per sixty (60) month period.
- **Tissue conditioning (upper and lower)** is limited to one (1) time per twenty four (24) month period.

Code	Description	Copayment
D5110	**Complete denture – maxillary**	$215
D5120	**Complete denture – mandibular**	$215
D5130	**Immediate denture – maxillary**	$235
D5140	**Immediate denture – mandibular**	$235
D5211	**Maxillary partial denture – resin base** (including any conventional clasps, rests and teeth)	$175
D5212	**Mandibular partial denture – resin base** (including any conventional clasps, rests and teeth)	$175

D5213 **Maxillary partial denture – cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth) $235
D5214 **Mandibular partial denture – cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth) $235
D5221 **Immediate maxillary partial denture - resin base** (including any conventional clasps, rests and teeth)..... $175
D5222 **Immediate mandibular partial denture - resin base** (including any conventional clasps, rests and teeth)..... $175
D5223 **Immediate maxillary partial denture- cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth) $235
D5224 **Immediate mandibular partial denture-cast metal framework with resin denture bases** (including any conventional clasps, rest and teeth) $235
D5225 **Maxillary partial denture – flexible base** (including any clasps, rests and teeth) $210
D5226 **Mandibular partial denture – flexible base** (including any clasps, rests and teeth) ... $210
D5281 **Removable unilateral partial denture - one piece cast metal** (including clasps and teeth..... $175
D5410 **Adjust complete denture – maxillary** $10
D5411 **Adjust complete denture – mandibular** $10
D5421 **Adjust partial denture – maxillary** $10
D5422 **Adjust partial denture – mandibular** $10
D5511 **Repair broken complete denture base** $40
D5512 **Repair broken complete denture base** $40
D5520 **Replace missing or broken teeth – complete denture (each tooth)** $20
D5611 **Repair repair resin partial denture base, mandibular** $30
D5612 **Repair resin partial denture base, maxillary** $30
D5621 **Repair cast partial framework, mandibular** $30
D5622 **Repair cast partial framework, maxillary** $30
D5630 **Repair or replace broken clasp** $30
D5640 **Replace broken teeth – per tooth** $20
D5650 **Add tooth to existing partial denture** $20
D5660 **Add clasp to existing partial denture** $30
D5670 **Replace all teeth and acrylic on cast metal framework (maxillary)** $135
D5671 **Replace all teeth and acrylic on cast metal framework (mandibular)** $135
D5710 **Rebase complete maxillary denture** $65
D5711 **Rebase complete mandibular denture** $65
D5720 **Rebase maxillary partial denture** $65
D5721 **Rebase mandibular partial denture** $65
D5730 **Reline complete maxillary denture (chairside)** $35
D5731 **Reline complete mandibular denture (chairside)** $35
D5740 **Reline maxillary partial denture (chairside)** $35
D5741 **Reline mandibular partial denture (chairside)** $35
D5750 **Reline complete maxillary denture (laboratory)** $75
D5751 **Reline complete mandibular denture (laboratory)** $75
D5760 **Reline maxillary partial denture (laboratory)** $75

D5761 **Reline mandibular partial denture (laboratory)** $75
D5810 **Interim complete denture (maxillary)** $245
D5811 **Interim complete denture (mandibular)** $245
D5820 **Interim partial denture (maxillary)** $90
D5821 **Interim partial denture (mandibular)** $90
D5850 **Tissue conditioning, maxillary** $15
D5851 **Tissue conditioning, mandibular** $15
D5862 **Precision attachment, by report** $200
D5863 **Overdenture-complete maxillary** $275
D5864 **Overdenture-partial maxillary** $250
D5865 **Overdenture-complete mandibular** $275
D5866 **Overdenture-partial mandibular** $250
D5899 **Unspecified removable prosthodontic procedure, by report** $0

Implant Supported Services

- There is a charge of $125 when using noble or high noble (precious) metals. This is in addition to your *copayment*.

- There is a $125 charge in addition to your *copayment* for porcelain to metal crowns placed on molars.

- **Implant supported prosthetics** are limited to one (1) time per sixty (60) month period.

- **Implant maintenance procedures** when prosthetics are removed and reinserted, including cleaning, are limited to one (1) time per twelve (12) month period.

- **Provisional implant crown** is limited to once per tooth per lifetime.

- **Replacement of replaceable part of semi-precision or precision attachment** (male or female component) is limited to one (1) time per sixty (60) month period.

Code	Description	Copayment
D6051	**Interim abutement**	$225
D6052	**Semi-precision attachment abutement**	$325
D6055	**Connecting bar – implant supported or abutment supported**	$500
D6056	**Prefabricated abutment – includes placement**	$320
D6057	**Custom abutment – includes placement**	$400
D6058	**Abutment supported porcelain/ceramic crown**	$435
D6059	**Abutment supported porcelain fused to metal crown (high noble metal)**	$425

D6060 **Abutment supported porcelain fused to metal crown (predominantly base metal) .** $335
D6061 **Abutment supported porcelain fused to metal crown (noble metal)** $390
D6062 **Abutment supported cast metal crown (high noble metal)** $400
D6063 **Abutment supported cast metal crown (predominantly base metal)** $320
D6064 **Abutment supported cast metal crown (noble metal)** $350
D6065 **Implant supported porcelain/ceramic crown** $435
D6066 **Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)** $425
D6067 **Implant supported metal crown (titanium, titanium alloy, high noble metal**) $440
D6068 **Abutment supported retainer for porcelain/ceramic FPD**..... $435
D6069 **Abutment supported retainer for porcelain fused to metal FPD** (high noble metal) $425
D6070 **Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)**..... $335
D6071 **Abutment supported retainer for porcelain fused to metal FPD (noble metal)** $390
D6072 **Abutment supported retainer for cast metal FPD (high noble metal)** $400
D6073 **Abutment supported retainer for cast metal FPD (predominantly base metal)** $320
D6074 **Abutment supported retainer for cast metal FPD (noble metal)** $350
D6075 **Implant supported retainer for ceramic FPD** $435
D6076 **Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)** $425
D6077 **Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)**..... $440
D6080 **Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis** $60
D6085 **Provisional implant crown**..... $160
D6090 **Repair implant supported prosthesis, by report** $150
D6091 **Replacement of semi-precision or precision attachment** (male or female component) of implant/abutment supported prosthesis, per attachment..... $90
D6092 **Recement implant/abutment supported crown** $40
D6093 **Recement implant/abutment supported fixed partial denture** $60
D6094 **Abutment supported crown – (titanium)** $440
D6095 **Repair implant abutment, by report** $130
D6110 **Implant/abutement supported removable denture for edentulous arch – maxillary**..... $415
D6111 **Implant/abutement supported removable denture for edentulous arch - mandibular**..... $415
D6112 **Implant/abutement supported removable denture for partially edentulous arch - maxillary**..... $435
D6113 **Implant/abutement supported removable denture for partially edentulous arch-mandibular** $435
D6114 **Implant/abutment supported fixed denture for edentulous arch – maxillary** $415
D6115 **Implant/abutment supported fixed denture for edentulous arch – mandibular** $415
D6116 **Implant/abutment supported fixed denture for partially edentulous arch – maxillary**..... $435

D6117 **Implant/abutment supported fixed denture for partially edentulous arch – mandibular** $435
D6118 **Implant/abutment supported interim fixed denture for edentulous arch – mandibular** $435
D6119 **Implant/abutment supported interim fixed denture for edentulous arch – maxillary** $435
D6194 **Abutment supported retainer crown for FPD – (titanium)** $440
D6199 **Unspecified implant procedure, by report** $0

Prosthodontic Services (Fixed)

- There is a charge of $125 when using noble or high noble (precious) metals. This is in addition to your *copayment*.
- There is a $125 charge in addition to your *copayment* for porcelain to metal placed on molars of a fixed bridge.
- A **Fixed Partial Denture (bridge)** is limited to one (1) time per sixty (60) month period.
- **Stress breaker** is limited to one (1) per sixty (60) months.
- **Precision attachment** is limited to one (1) per sixty (60) month period.
- If a treatment plan involves six (6) or more crowns and/or fixed bridge units/teeth, an additional charge of $125 per unit/tooth will be charged.

Crowns/Fixed Bridges – per unit/tooth

Code	Description	Copayment
D6205	**Pontic – indirect resin based composite**	$55
D6210	**Pontic – cast high noble metal**	$200
D6211	**Pontic – cast predominantly base metal**	$120
D6212	**Pontic – cast noble metal**	$150
D6214	**Pontic – titanium**	$240
D6240	**Pontic – porcelain fused to high noble metal**	$225
D6241	**Pontic – porcelain fused to predominantly base metal**	$135
D6242	**Pontic – porcelain fused to noble metal**	$190
D6245	**Pontic – porcelain/ceramic**	$235
D6250	**Pontic – resin with high noble metal**	$170
D6251	**Pontic – resin with predominantly base metal**	$85

D6252 **Pontic – resin with noble metal** $135
D6253 **Provisional pontic** $60
D6545 **Retainer – cast metal for resin bonded fixed prosthesis** $125
D6548 **Retainer – porcelain/ceramic for resin bonded fixed prosthesis** $125
D6549 **Resin retainer - for resin bonded fixed prosthesis** $125
D6600 **Inlay – porcelain/ceramic, two surfaces** $180
D6601 **Inlay – porcelain/ceramic, three or more surfaces** $190
D6602 **Inlay – cast high noble metal, two surfaces** $170
D6603 **Inlay – cast high noble metal, three or more surfaces** $180
D6604 **Inlay – cast predominantly base metal, two surfaces** $150
D6605 **Inlay – cast predominantly base metal, three or more surfaces** $160
D6606 **Inlay – cast noble metal, two surface**s $160
D6607 **Inlay – cast noble metal, three or more surfaces** $170
D6608 **Onlay – porcelain/ceramic, two surfaces** $175
D6609 **Onlay – porcelain/ceramic, three or more surfaces** $185
D6610 **Onlay – cast high noble metal, two surfaces** $180
D6611 **Onlay – cast high noble metal, three or more surfaces** $185
D6612 **Onlay – cast predominantly base metal, two surfaces** $160
D6613 **Onlay – cast predominantly base metal, three or more surfaces** $165
D6614 **Onlay – cast noble metal, two surfaces** $170
D6615 **Onlay – cast noble metal, three or more surfaces** $175
D6624 **Inlay – titanium** $170
D6634 **Onlay – titanium** $175
D6710 **Crown – indirect resin based composite** $55
D6720 **Crown – resin with high noble metal** $170
D6721 **Crown – resin with predominantly base metal** $85
D6722 **Crown – resin with noble metal** $135
D6740 **Crown – porcelain/ceramic** $235
D6750 **Crown – porcelain fused to high noble metal** $225
D6751 **Crown – porcelain fused to predominantly base metal** $135
D6752 **Crown – porcelain fused to noble metal** $190
D6780 **Crown – 3/4 cast high noble metal** $190
D6781 **Crown – 3/4 cast predominantly base metal** $110
D6782 **Crown – 3/4 cast noble metal** $140
D6783 **Crown – 3/4 porcelain/ceramic** $215
D6790 **Crown – full cast high noble metal** $200
D6791 **Crown – full cast predominantly base metal** $120
D6792 **Crown – full cast noble metal** $150
D6793 **Provisional retainer crown** $60
D6794 **Crown – titanium** $240
D6930 **Recement fixed partial denture** $15
D6940 **Stress breaker** $25
D6950 **Precision attachment** $220
D6980 **Fixed partial denture repair, by report** $30

D6999 **Unspecified fixed prosthodontic procedure, by report** $0

Oral Surgery Services

- **Surgical extractions includes** local anesthesia and routine post - operative care.

- **Incision and drainage of abscess, either intraoral or extraoral**, is not covered in hospital or surgical settings.

- **Regional block anesthesia, trigeminal division block anesthesia or local anesthesia** are inclusive with operative or surgical procedures.

The following oral surgery procedures is limited to one (1) time per lifetime per tooth:

- **Transeptal Fiberotomy**
- **Bone replacement graft for ridge preservation**

Code	Description	Copayment
D7111	**Extraction, coronal remnants** – deciduous tooth	$5
D7140	**Extraction, erupted tooth or exposed root** (elevation and/or forceps removal)	$5
D7210	**Surgical removal of erupted tooth** requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	**Removal of impacted tooth – soft tissue**	$50
D7230	**Removal of impacted tooth – partially bony**	$70
D7240	**Removal of impacted tooth – completely bony**	$90
D7241	**Removal of impacted tooth – completely bony, with complications**	$110
D7250	**Surgical removal of residual tooth roots** (cutting procedure)	$40
D7251	**Coronectomy** – intentional partial tooth removal	$110
D7260	**Oroantral fistula closure**	$275
D7261	**Primary closure of a sinus perforation**	$275
D7270	**Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth**	$95
D7280	**Surgical access of an unerupted tooth**	$85
D7282	**Mobilization of erupted or malpositioned tooth to aid eruption**	$85
D7283	**Placement of device to facilitate eruption of impacted tooth**	$0
D7285	**Biopsy of oral tissue – hard** (bone, tooth)	$75
D7286	**Biopsy of oral tissue – soft**	$75
D7287	**Exfoliative cytological sample collection**	$65
D7288	**Brush biopsy – transepithelial sample collection**	$50
D7290	**Surgical repositioning of teeth**	$130
D7291	**Transseptal fiberotomy/supra crestal fiberotomy, by report**	$55

D7310 **Alveoloplasty in conjunction with extractions** – four or more teeth or tooth spaces, per quadrant $50
D7311 **Alveoloplasty in conjunction with extractions** – one to three teeth or tooth spaces, per quadrant $50
D7320 **Alveoloplasty not in conjunction with extractions** – four or more teeth or tooth spaces, per quadrant $65
D7321 **Alveoloplasty not in conjunction with extractions** – one to three teeth or tooth spaces, per quadrant $65
D7340 **Vestibuloplasty – ridge extension (secondary epithelialization)** $350
D7350 **Vestibuloplasty – ridge extension** (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)..... $550
D7410 **Excision of benign lesion up to 1.25 cm** $80
D7411 **Excision of benign lesion greater than 1.25 cm** $110
D7412 **Excision of benign lesion, complicated** $160
D7413 **Excision of malignant lesion up to 1.25 cm** $90
D7414 **Excision of malignant lesion greater than 1.25cm** $110
D7415 **Excision of malignant lesion, complicated** $220
D7450 **Removal of benign odontogenis cyst or tumor, lesion diameter up to 1.25cm** $80
D7451 **Removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25cm**..... $140
D7460 **Removal of benign nonodontogenic cyst or tumor- lesion diameter up to 1.25cm**..... $80
D7461 **Removal of benign nonodontogenic cyst or tumor- lesion diameter greater than 1.25cm**..... $140
D7465 **Destruction of lesions(s) by physical or chemical method**, by report..... $50
D7471 **Removal of lateral exostosis (maxilla or mandible)** $45
D7472 **Removal of torus palatinus** $45
D7473 **Removal of torus mandibularis** $45
D7485 **Surgical reduction of osseous tuberosity** $80
D7510 **Incision and drainage of abscess – intraoral soft tissue** $25
D7511 **Incision and drainage of abscess – intraoral soft tissue – complicated** (includes drainage of multiple fascial spaces) $40
D7520 **Incision and drainage of abscess – extraoral soft tissue** $45
D7521 **Incision and drainage of abscess – extraoral soft tissue – complicated** (includes drainage of multiple facial spaces) $125
D7530 **Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue** $80
D7540 **Removal of reaction producing foreign bodies, muscuoskeketal system**..... $110
D7550 **Partial ostectomy/sequestrectomy for removal of non-vital bone** $115
D7560 **Maxillary sinusotomy for removal of tooth fragment or foreign body** $495
D7910 **Suture of recent small wounds up to 5 cm** $75
D7911 **Complicated suture- up to 5cm** $55
D7912 **Complicated suture- greater than 5 cm** $115
D7953 **Bone replacement graft for ridge preservation – per site** $100

D7960 **Frenulectomy – also known as frenectomy or frenotomy** – separate procedure not incidental to another procedure $50
D7963 **Frenuloplasty** $50
D7970 **Excision of hyperplastic tissue – per arch** $65
D7971 **Excision of pericoronal gingiva** $55
D7972 **Surgical reduction of fibrous tuberosity** $120
D7999 **Unspecified oral surgery procedure, by report** $0

Orthodontic Services

These are services given to straighten the teeth through the use of braces. This is a description of your orthodontic benefits under this *plan*. These benefits are subject to the terms, conditions, limitations and exclusions of your Evidence of Coverage.

Before you get orthodontic care, you must get a written referral from us. Once you get a referral, you will select an orthodontist from within the Dental Net participating provider network to receive all of your orthodontic care. Call us at the following number to get a referral or if you need help selecting an orthodontist:

☎ **1 (800) 627-0004**

Orthodontic Consultation. This is the initial consultation to determine what orthodontic care will be needed.

Orthodontic Treatment in Progress
Continuing Orthodontic treatment is available if You or Your Dependent qualify by enrolling within 30 days of the *Effective Date* for an eligible Subscriber; You or Your Dependent had Orthodontic coverage under the Subscribers prior plan and were in active Orthodontic treatment, covered by that plan, as of the *Effective Date* of this group policy.

The orthodontia benefit balance may be pro-rated over the remaining length of treatment **up to $1,695 for a child and $1,895 for an adult** as of this group policy's *Effective Date*. The continuing orthodontic provision is not available:
- thirty (30) days after this group policy's *Effective Date*;
- to a person who enrolls after the group policy's *Effective Date*; or
- to a person who is not in active orthodontic treatment as of the *Effective Date* of this group policy.

Orthodontic x-rays.
D0340 **Cephalometric film** $0
D0350 **Oral/facial photographic images** $0

Orthodontic Treatment. Standard orthodontic treatment is fully banded cases with brackets and arch wires attached by bands or adhesive to correct malocclusion. An alternative to metal braces is Invisalign; clear orthodontic aligners that fit snugly over your teeth and are changed every one (1) to six (6) weeks to gradually move and straighten teeth. Each type of appliance, metal banding and Invisalign, are covered under this *plan*.

Orthodontic treatment options covered under your *plan* may include the following procedures. The fees for these treatment options are included in the *copayment* for adult and child orthodontic services listed below. All of these procedures are limited to once per lifetime.

D8010 **Limited treatment of the primary dentition**
D8020 **Limited treatment of the transitional dentition**
D8030 **Limited treatment of the adolescent dentition**
D8040 **Limited treatment of the adult dentition**
D8050 **Interceptive treatment of the primary dentition**
D8060 **Interceptive treatment of the transitional dentition**
D8070 **Interceptive treatment of the transitional dentition**
D8080 **Comprehensive treatment of the transitional dentition**
D8090 **Comprehensive treatment of the adult dentition**
D8660 **Pre-orthodontic treatment examination to monitor growth and development and treatment plan**.

Your *plan* covers the following orthodontic services as needed:

D8670 **Periodic orthodontic treatment visits** $0
D8681 **Removable orthodontic retainer adjustment** $0
D8999 **Unspecified orthodontic procedure** $100

We will cover up to 24 months of orthodontic treatment. Orthodontic treatment is limited to once per lifetime. Your *copayment* for twenty-four (24) months of orthodontic services excluding records/retention fees are listed as follows:

- Adults.....$1,895
- Children.....$1,695

Orthodontic Retention Phase. Orthodontic retention is the phase of care that follows standard orthodontic treatment and includes the removal of orthodontic appliances (braces), as well as the construction, placement, and adjustment of retainers. Up to twenty-four (24) months of orthodontic retention is covered under this *plan*.

You are responsible for the following *copayment* for orthodontic retention (retainer):

D8680 **Orthodontic Retention (Retainers) -** (includes removal of appliances, construction and placement of retainers) $250

Minor Treatment to Control Harmful Habits is appliance therapy including appliances for thumb sucking and thumb thrusting. Each of these appliances are covered once per lifetime and you are responsible for the following *copayments* for minor treatment to control harmful habits:

D8210 **Removable appliance therapy** $350
D8220 **Fixed appliance therapy** $350

Orthodontic Limitations and Exclusions

These limitations and exclusions are in addition to those listed under **GENERAL EXCLUSIONS**.

Your Coverage Ends. If your coverage under this *plan* ends while you are in the process of your orthodontic care, you will be responsible for any additional charges incurred for the remainder of your orthodontic care.

Changes in Treatment. Changes in treatment required because of an accident or patient non-compliance.

Myofunctional Therapy. Myofunctional therapy is the use of muscle exercises in addition to orthodontic treatment to correct malocclusion. Myofunctional therapy and related services are not covered under this *plan*.

Orthodontic Retreatment.

Orthodontic Pre-Treatment. Any treatment or services that your *dentist* deems necessary or advantageous in order to begin standard orthodontic treatment.

Orthodontic Appliance Replacement. Replacement of lost or stolen orthodontic appliance, or the repair of broken appliances due to your negligence.

Special Orthodontic Appliances. Appliances which are considered cosmetic, such as sapphire, ceramic, or lingual braces. Also includes, but is not limited to, headgear, and bite planes, or palatal expanders.

TMJ or Hormonal Imbalance Orthodontic Care. Orthodontic treatment that is related to temporomandibular joint disturbances (TMJ) or hormonal imbalance.

Adjunctive General Services

These are various, miscellaneous dental services.

- **General anesthesia, Intravenous Sedation and Non-Intravenous Sedation** are covered when given in conjunction with covered complex oral surgical and periodontal surgical procedures.

- **Occlusal guard** is limited to once per twenty four (24) month period for the treatment of bruxism.

- **Repair and/or reline of occlusal guard** is limited to one (1) time per twelve (12) month period. Six (6) months must have passed since original placement of the occlusal guard.

- **External Bleaching**, per arch and per tooth is limited to one (1) time per twelve (12) month period.

- **External bleaching per arch for home application** is limited to once per twelve (12) month period.

- **Consultation -** Limited to once per twelve (12) month period only with x-rays and not on the same day as any other service.

Code	Description	Copayment
D9110	**Palliative (emergency) treatment** of dental pain – minor procedure	$10
D9120	**Fixed partial denture sectioning**	$35
D9210	**Local anesthesia not in conjunction with operative or surgical procedures**	$0
D9211	**Regional block anesthesia**	$0
D9212	**Trigeminal division block anesthesia**	$0
D9215	**Local anesthesia in conjunction with operative or surgical procedures**	$0
D9219	**Evaluation for deep sedation or general anesthesia**	$0
D9222	**Deep sedation/general anesthesia- first 15 minutes**	$130
D9223	**Deep sedation/general anesthesia- each subsequent 15 minute increment**	$75
D9230	**Inhalation of nitrous oxide/anxiolysis, analgesia**	$15
D9239	**Intravenous moderate (conscious) sedation/analgesia- first 15 minutes**	$150
D9243	**Intravenous moderate (conscious) sedation/analgesia-each subsequent 15 minute increment**	$75
D9248	**Non-intravenous conscious sedation**	$15
D9310	**Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician**	$10
D9430	**Office visit for observation** (during regularly scheduled hours) – no other services performed	$20
D9440	**Office visit – after regularly scheduled hours**	$25
D9450	**Case presentation, detailed and extensive treatment planning**	$0

D9610 **Therapeutic parenteral drug**, single administration $15
D9612 **Therapeutic parenteral drugs, two or more administrations, different medications** $25
D9630 **Other drugs and/or medicaments, by report** $15
D9910 **Application of desensitizing medicament** $15
D9911 **Application of desensitizing resin for cervical and/or root surface, per tooth** $15
D9930 **Treatment of complications (post-surgical) – unusual circumstances, by report** $0
D9932 **Cleaning and inspection of removable complete denture, maxillary** $0
D9933 **Cleaning and inspection of removable complete denture, mandibular** $0
D9934 **Cleaning and inspection of removable partial denture, maxillary** $0
D9935 **Cleaning and inspection of removable partial denture, mandibular** $0
D9940 **Occlusal guard, by report** $105
D9942 **Repair and/or reline of occlusal guard** $40
D9943 **Occlusal guard adjustment** $20
D9951 **Occlusal adjustment – limited** $45
D9952 **Occlusal adjustment – complete** $55
D9972 **External bleaching – per arch** $125
D9973 **External bleaching – per tooth** $50
D9975 **External bleaching per arch for home application** $125
D9986 **Missed appointment** (less than 24 hour notice) $25
D9987 **Canceled appointment** $25
D9991 **Dental Case Management-addressing appointment** $0
D9992 **Dental Case management-care coordination** $0
D9993 **Dental Case management-motivational interviewing** $0
D9994 **Dental Case management-patient education to improve oral health literacy** $0
D9995 **Teledentistry - synchronous, real time encounter** $0
D9996 **Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review** $0
D9999 **Unspecified adjunctive procedure** $10

Enhanced Dental Services

Enhanced dental benefits are available if your *Dentist* has diagnosed **additional preventive or periodontal services are medically necessary** for your dental condition.

D1110 **Prophylaxis** – each additional cleaning for **adult** $45
D1120 **Prophylaxis** – each additional cleaning for **child** $35
D1206 **Topical fluoride varnish**; therapeutic application for moderate to high caries risk patients $15
D1208 **Topical application of fluoride-excluding varnish** $15
D4910 **Periodontal maintenance** $55

Dental Terminology

The following definitions give you a brief description of the dental terminology that is used within the **SCHEDULE OF COPAYMENTS**.

Amalgam. A silver filling.

Anterior. Teeth that are in the front of the mouth.

Bicuspid. Most people have eight bicuspid teeth. They are located immediately before the molar teeth. There are two bicuspid teeth in each quadrant of the mouth.

Bridge. A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty spaces.

Crown. A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials, such as metal (base, noble, high noble), porcelain, or a combination of metal and porcelain.

Endodontics. Procedures that treat the nerve or the pulp of the tooth that has been injured or infected.

Oral Surgery. Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics. Standard braces and other procedures to straighten the teeth. Please see the section **ORTHODONTIC SERVICES** for more information about orthodontic services.

Periodontics. Procedures related to treatment of the supporting structures of the teeth, such as gums or underlying bone.

Posterior. Teeth that are in the back of your mouth, such as molars and bicuspids.

Primary Teeth. The first set of teeth, also known as "baby teeth".

Prophylaxis. A dental cleaning that involves scaling and polishing the teeth to remove plaque above the gum line.

Prosthodontics. The restoration of natural and/or the replacement of missing teeth with artificial substitutes, such as dentures or bridges.

Quadrant. One of the four equal sections into which your mouth can be divided. Some procedures, such as periodontics, are done in quadrants.

Resin-based Composite. A tooth colored or white filling.

General Exclusions

The following is a list of services that are not covered under this *plan*. The titles given to the exclusions and limitations are for reference only. They are not an integral part of the exclusion or limitation.

Services Not Listed. Dental care services that are not specifically listed in the **SCHEDULE OF COPAYMENTS** are not covered under this *plan*. This includes hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Dental Procedure Code.

Not Acceptable Services. Services or supplies that we have determined are not an *acceptable service*.

Not Medically Necessary. Services or supplies that are not considered *medically necessary*.

Services Received Before or After Your Term of Coverage. Dental care you receive either before your *effective date* or after your coverage ends.

Dental Care Outside of the Dental Net Network. Except as provided in the section **HOW TO GET CARE WHEN YOU NEED IT: EMERGENCY CARE**, services given by a dentist or dental office that is not a part of the Dental Net network will not be covered under this *plan*. Also, we will not cover services that are needed as a result of dental care given by a dentist or dental office that is not a part of the Dental Net network.

Not Generally Accepted. Services that are *experimental or investigative* or are not generally accepted standards of dental practice.

Government Programs. Care or treatment that is given by or paid for by any Federal, State, or other government agency, including any foreign government.

Workers' Compensation. Any condition for which benefits of any nature are recoverable, whether by adjudication or settlement, under any workers' compensation law, even if you did not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903.

Armed Forces. Dental services required while serving in the Armed Forces of any country or international authority.

Lack of Cooperation. We will not pay for any dental services or supplies needed because of your lack of cooperation with a *dentist* or failure to comply with your *dentist's* treatment plan.

Member Health Limitations. Charges for dental care that cannot be performed by your *dentist* because of your general health, mental or emotional behavior, or physical limitations.

Least Expensive Acceptable Treatment. If there is more than one treatment plan available for your dental condition, we will cover the least expensive treatment.

Consultations for Services That are Not Covered. Consultations from a specialist for dental care services that are not listed in the section **WHAT IS COVERED: SCHEDULE OF COPAYMENTS**.

Cosmetic Dentistry. Unless shown as a covered service in the **WHAT IS COVERED: SCHEDULE OF COPAYMENTS**, dental care that is only to improve your appearance when tooth structure and function are satisfactory and no pathologic conditions (decay) exist.

Congenital (Hereditary) or Developmental Malformations. Treatment of congenital or developmental malformations. Including enamel hypoplasia, fluorosis, anodontia, supernumerary, over retained primary teeth, or impacted teeth (other than third molars).

Extensive Oral Rehabilitation. Dental treatment or procedures given for fixed prosthodontic restorations when part of extensive oral rehabilitations or reconstruction (other than for replacement of structure lost due to dental decay).

Fractures or Dislocations of the Jaw. Services for fractures or dislocations of the jaw.

Certain X-Ray Services. Such as lateral skull surveys, sialography, x-rays related to temporomandibular joint dysfunction, tomographic survey, cone beam, MRI, ultrasound and sialoendoscopy.

General Anesthesia, Intravenous and Non-Intravenous Sedation. Covered when given in conjunction with covered complex oral surgical and periodontal surgical procedures.

Hospital Charges. Hospital and associated physician charges of any kind or charges for any dental treatment that cannot be performed in a dental office.

Implants. Any services for placement or removal of implants unless you have an optional Implant Benefit Rider.

Lost or Stolen. Replacement of crowns, dentures, bridgework, or other dental appliances that have been lost, stolen or damaged due to misuse or neglect.

Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure loss from tooth decay) that are necessary to alter, restore or maintain occlusion. Exclusion does not apply to alteration by removable prosthodontics.

Surgical Services. Orthognathic surgery procedures are not covered.

Temporomandibular Joint (TMJ): Diagnosis or treatment, by any method, of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Prescription Drugs. Any prescription drugs.

Poor Prognosis. Endodontic treatment, periodontal surgery, or crown/bridge work is not covered on teeth with questionable, guarded or poor prognosis. We will allow for observation or extraction and prosthetic replacement.

Third Molars. The extraction of immature erupting third molars and non-pathologic asymptomatic third molars is excluded.

Primary Restorations. Gold and porcelain fillings on primary teeth are excluded.

Denture Replacement. Full or partial dentures will be replaced only if they are at least five years old and cannot be made serviceable.

Who is Covered and When

Your group decides who and when you are eligible for coverage under this *plan*. To be covered under this *plan* you and your *family members* must meet your group's eligibility requirements listed below.

Eligibility

1. **Subscribers.** Permanent *full-time employees* are eligible to enroll as *subscribers*. For specific information about your employer's eligibility rules for coverage, please contact your Human Reources or Benefits Department.

2. **Family Members.** The following are eligible to enroll as *family member*s: (a) Either the *subscriber's* spouse or domestic partner*;* and (b) A child.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber*'s domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

3. **Child** is the *subscriber's*, spouse's or domestic partner's natural child, stepchild, or legally adopted child, or a child for whom the *subscriber,* spouse*,* or domestic partner has been appointed legal guardian by a court of law, subject to the following:

    a. The child is under 26 years of age.

    b. The child is 26 years of age or older and: (i) is chiefly dependent on the *subscriber,* spouse or domestic partner for support and maintenance*,* and (ii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber,* spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

   Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber's*, the spouse's or domestic partner's right to control the health care of the child.

d. A child for whom the *subscriber,* spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

Eligibility Date

1. For Subscribers: You become eligible for coverage in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *family members,* you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

Enrollment

To enroll as a *subscriber,* or to enroll *family members,* the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 31 days from your eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

Effective Date

Your *effective date* of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers,* on your eligibility date; and (b) for *family members,* on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement,* provided the enrollment application is on time and in order.

2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the *group*'s next open enrollment period to enroll.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "**Enrollment**" provision above, during the *group*'s next open enrollment period (see **Open Enrollment Period**).

For late enrollees and disenrollees: You may enroll earlier than the *group*'s next open enrollment period if you meet any of the conditions listed under **special enrollment periods**.

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the *subscriber,* spouse or domestic partner will be enrolled from the moment of birth; and (2) any child being adopted by the *subscriber,* spouse or domestic partner will be enrolled from the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the *subscriber,* spouse or domestic partner the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's,* spouse's or domestic partner's right to control the health care of the child may be used)*;* or (b) the *subscriber,* spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For the child's enrollment to continue beyond this 31-day period, the *subscriber* must submit a membership change form to the *group* within the 31-day period. We must then receive the form from the *group* within 90 days.

Special Enrollment Periods

You may enroll without waiting for the *group*'s next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. When we or your *group* cannot produce a form showing that you said you did not want to enroll because you had other health care coverage.
2. When you did not enroll in this *plan* before because:
   a. You had CalCOBRA or COBRA coverage and it has now ended;
   b. You had Healthy Families or Medi-Cal with no share-of-cost, and now you no longer qualify for it; or
   c. You were covered by another group dental plan, and now that coverage has ended.
3. When a court orders that you cover a current spouse or minor child on your health plan.
4. You have new *family member* due to a marriage, a new domestic partnership, or through birth or adoption.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after we receive a copy of the court order

or of a request from the district attorney, either parent or the person having custody of the child, the employer, or the *group* administrator.

2. For enrollments following the birth, adoption, or placement for adoption of a child, coverage will be effective as of the date of birth, adoption, or placement for adoption.

Open Enrollment Period

The *group* has an open enrollment period once each year. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family member*s at that time. Persons eligible to enroll as *family member*s may enroll only under the *subscriber's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the open enrollment period. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

This section will tell you how your coverage ends. Unless otherwise stated, your coverage will end on the next subscription charge due date after the event. Unless otherwise stated, we will send a notice of cancellation 30 days before your coverage ends. Your coverage will end as provided below:

1. If the *agreement* terminates, your coverage ends at the same time.
2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If this *agreement* is amended to delete coverage for *family member*s, a *family member*'s coverage ends on the effective date of that change.
3. Coverage for *family member*s ends when the *subscriber's* coverage ends.
4. If your employer does not pay the required subscription charges for your coverage within the grace period. The grace period is 30 days. Your coverage will remain in force until the end of the grace period.
5. If you tell us in writing that you want to cancel coverage.
6. If you no longer meet the requirements set forth in the **WHO IS COVERED AND WHEN: ELIGIBILITY**.
7. If you or your *family members* knowingly engage in any fraud or misuse of the benefits of this *plan*. Your coverage will end on the date we send the written notice of cancellation.
8. If you or your employer made any fraudulent misstatements on your application. We will send written notice of cancellation at least 15 days before your coverage ends.
9. If you interfere with the normal operations of the dental office.
10. If you use threatening or aggressive behavior.

Exceptions to Item 6:
Leave of Absence. If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former spouse or domestic partner, and their dependent children, if any, ends according to the "Eligible Status" provisions. If Anthem suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under **INDIVIDUAL CONTINUATION OF BENEFITS**.

If you think we should NOT have ended (terminated) your coverage:
We cannot end your coverage because of your dental needs or dental condition. If you think that we wrongly ended your coverage, you can file a complaint with us as described in the section **GRIEVANCE PROCEDURES**. You may also file a complaint with the State of California Health Plan Help Center at 1-888-HMO-2219.

Individual Continuation of Benefits

COBRA

COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.

COBRA may allow you and your *family members* to keep your coverage under this *plan* for up to 18 or 36 months, depending on the qualifying event and other circumstances. With COBRA, you have the same benefits as current employees in the group. In order to have COBRA coverage, you will have to pay all of the monthly subscription charges.

Each qualified person may independently elect to get COBRA coverage. A parent or legal guardian may elect COBRA for a minor child.

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

1. Notification of qualifying events:
    a. Employers must notify the plan administrator within 30 days after the following qualifying events:
        i. The *subscriber's* job ends;
        ii. The *subscriber's* hours of employment are reduced;
        iii. The *subscriber* becomes eligible to receive Medicare benefits; or
        iv. The *subscriber* dies
    b. You or your *family member* must notify the employer in writing within 60 days after any of the following qualifying events:
        i. The *subscriber* divorces or legal separates;
        ii. A child or other *family member* is no longer eligible for coverage under this *plan*.
2. Election notice – generally, you must be sent an election notice not later than 14 days after the plan administrator receives notice that a qualifying even has occurred.
3. Election period – you have 60 days to notify the plan administrator in writing that you want to elect COBRA coverage. The 60 days starts on the later of the following two dates:
    a. The date you receive the election notice; or
    b. The date your coverage with this *plan* ended.
4. Subscription charges – you must pay the subscription charges for your COBRA coverage. We must receive your first payment within 45 days after you elect COBRA coverage. This first payment covers the time from the date your coverage ended because of the qualifying event up to the day you signed up for COBRA. You must then pay a monthly subscription charge as long as you stay on COBRA.

You will lose COBRA if:

1. You do not pay your subscription charges on time;
2. You move outside the service area for this *plan*;
3. Your former employer no longer offers any health plan;
4. You become eligible for Medicare;
5. You sign up for another plan - If your new plan has a waiting period for pre-existing conditions and you have not used up all of your COBRA coverage, you can keep COBRA until the waiting period is over;
6. You commit fraud, which means that you intentionally deceive us or misrepresent yourself or allow someone else to do so in order to get health care services.

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

Continuation of Coverage – Cal-Cobra

If the Group is an Employer with between two (2) and nineteen (19) full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with these provisions, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must qualify as described below, and you and the Group must also satisfy the requirements set out below.

Definitions

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this definitions provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the terms of cal-cobra continuation provisions below.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Certificate as either a Subscriber or Dependent, (b) a Child who is born to or placed for adoption with the Subscriber during the Cal-COBRA continuation period, or (c) a Child for whom the Subscriber or Spouse has been appointed permanent legal guardian by final court decree or order during the Cal-COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any Dependents acquired during the Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the Certificate. The event will be referred to throughout this section by letter/number.

A. **For Subscribers and Dependents**:

1. The Subscriber's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Subscriber's work hours.

B. **For Dependents**:

1. The death of the Subscriber;
2. The Spouse's divorce or legal separation from the Subscriber;
3. The end of a Child's status as a Dependent Child, as defined by the Certificate;
1. The Subscriber's entitlement to Medicare; or
2. The loss of eligible status by an enrolled Dependent.

Eligibility For Cal-Cobra Continuation

A Subscriber or Dependent may choose to continue coverage under the Certificate if his or her coverage would otherwise end due to a Qualifying Event.

Exception: A Qualified Beneficiary is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the Qualified Beneficiary is entitled to Medicare; (2) the Qualified Beneficiary is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary; (3) we fail to receive timely notice of the Qualifying Event or election, as set out below, of a Cal-COBRA continuation, or (4) the Qualified Beneficiary fails to submit the required premium as set out below. If one Qualified Beneficiary is unable to continue coverage for these reasons, other entitled qualified beneficiaries may still choose to continue their coverage.

Terms Of Cal-Cobra Continuation

1. For Qualifying Event A., above, the Group must notify the Subscriber and us within 31 days of the Qualifying Event of the right to continue coverage. We in turn must, within 14 days, give you official notice of the Cal-COBRA continuation right.

2. You must inform us within 60 days of the Qualifying Event B., above, if you wish to continue coverage. We in turn must within 14 days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within 60 days of the date you receive notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all qualified beneficiaries within a covered family, or only for selected qualified beneficiaries.

If you fail to elect the Cal-COBRA continuation during the Initial Enrollment Period, you may not elect the Cal-COBRA continuation at a later date.

The initial premium must be delivered to us within 45 days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial premium must be delivered to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA. 93031-9062 by certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all premiums due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay premiums due will disqualify you from continuing coverage**.

Additional Dependents. A Child acquired during the Cal-COBRA continuation period is eligible to be enrolled as an Qualified Beneficiary. The standard enrollment provisions of the Certificate apply to enrollees during the Cal-COBRA continuation period. A Dependent acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. The Group may require that you pay the entire cost of your Cal-COBRA continuation coverage. This cost, called the "premium", must be remitted to us each month during the Cal-COBRA continuation period and shall be up to 110% of the rate applicable to a Qualified Beneficiary for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force**.

Besides applying to the Subscriber, the Subscriber's rate also applies to:

1. A Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber;

2. A Child if neither the Subscriber nor the Spouse has enrolled for this Cal-COBRA continuation coverage (if more than one Child is so enrolled, the premium will be based on the two-party or three-party rate depending on the number of Children enrolled); and

3. A Child whose Cal-COBRA continuation began due to the person no longer meeting the Dependent Child definition.

Subsequent Qualifying Events. Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, a Qualified Beneficiary who is a Qualified Beneficiary may be entitled to an extended Cal-COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first Qualifying Event.

For example, a Child may have been originally eligible for Cal-COBRA continuation due to termination of the Subscriber's employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the Child reaches the upper age limit of the plan, the Child is eligible to remain covered for the balance of the continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When Cal-COBRA Continuation Begins. When Cal-COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For Dependents properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Certificate.

When the Cal-COBRA Continuation Ends - For Qualified beneficiaries, this continuation will end on of the earliest of:

1. The end of thirty-six (36) months from the Qualifying Event;*

2. The date the certificate terminates;

3. The end of the period for which premiums are last paid;

4. The date the Qualified Beneficiary becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

5. The date the Qualified Beneficiary becomes eligible for Medicare.

*For an Qualified Beneficiary whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation coverage under this *plan* ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER

Note: This section ("POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER") applies ONLY to Qualified Beneficiaries turning sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums stated in the Certificate, coverage under this *Plan* may be continued for the Subscriber, the Subscriber's Spouse and the Subscriber's former Spouse (if any) under Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation may be elected following the **CAL-COBRA CONTINUATION OF COVERAGE** shown above.

For the purpose of this section, "former Spouse" means (a) an individual who is divorced from the Subscriber; or (b) an individual who was married to the Subscriber at the time of the Subscriber's death.

Requirements: The Subscriber and Spouse may continue coverage under this *Plan* if:

1. The Subscriber, or the Subscriber on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under Cal-COBRA as described in the preceding section;

2. The Subscriber or Spouse has not elected to continue coverage under any other available continuation;

3. The Subscriber has worked for the employer for at least the prior five (5) years and

4. The Subscriber is at least 60 years old on the date employment with the Group ended.

The former Spouse may continue coverage under this *plan* in accordance with this section if he or she was covered as a Qualified Beneficiary under Cal-COBRA.

TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

Note: **This section ("TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE") applies ONLY to Qualified Beneficiaries turning sixty (60) years of age prior to January 1, 2005**.

Notice and Election. We will notify you and your Spouse or former Spouse of the right to an extension in your continuation of coverage at least 90 days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify us in writing within 30 days prior to the end of your Cal-COBRA continuation period.

If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

Cost of Coverage. The Group may require that you pay the entire cost of your Cal-COBRA extended coverage. This cost, called the "premium", must be remitted to us each month during the Cal-COBRA extended continuation period and shall be up to 110% of the rate applicable to a Qualified Beneficiary for whom a Qualifying Event has not occurred. **We must receive proper and timely payment of the premium each month from you in order to maintain the coverage in force**.

Besides applying to the Subscriber, the Subscriber's rate also applies to a Spouse or former Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber.

When Post Cal-COBRA Continuation Ends. This continuation will end on the earliest of:

1. The date the Certificate terminates;

2. The end of the period for which premiums are last paid;

3. The date the Qualified Beneficiary becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary, in which case this Cal-COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

4. The date the Qualified Beneficiary becomes eligible for Medicare.

5. For a Spouse or Former Spouse of the Subscriber, five (5) years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the Subscriber.
   The date on which the employer or former employer terminates its group Subscriber Certificate with the health care service plan and no longer provides coverage for any active employees through the plan.

General Provisions

Independent Contractors: Our relationship with the *participating dental office* is that of an independent contractor. *Dentists* and other dental professionals within the *participating dental office* are not our agents or employees, nor are we, or any of our employees, an employee or agent of any *participating dental office*. We are not responsible for any damages or injuries as a result of receiving services from *participating dental offices*.

Public Policy Participation: We have established a public policy committee that we call our Consumer Relations Committee. This committee includes providers, members, and a member of our Board of Directors. If you would like to be considered for this committee, please write to us at Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, California 91367. The Committee advises our Board of Directors (the Board) about how to assure the comfort, convenience, and dignity of our *members*. The Committee may also review our financial information, as well as information about the complaints we receive.

Renewal Provisions. Your employer's *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of this *plan* from time to time.

Benefits Not Transferable: You and your dependents are the only persons able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Provider Reimbursement: Dental Net dental offices are generally paid a set dollar amount per member each month. This is called a capitation fee. On certain procedures, the dental office may also receive a supplemental payment. Specialty offices are paid on a fee-for-service basis. They are paid for the services given based upon an agreed fee schedule. Please contact us if you have any questions about provider reimbursement.

You are not liable to pay our providers for amounts that we owe, even in the unlikely event that we fail to pay them.

Plan Administrator for COBRA and ERISA: In no event will we be the plan administrator for the purposes of compliance with Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERSIA). The term "plan administrator" in this booklet refers to either your employer or a person or entity appointed by the employer to perform or assist in the administrative tasks for the *group*'s health plan. The employer is responsible for the satisfaction of notice, disclosure and other obligations of administrators as defined by ERISA. In providing notices and performing under the **INDIVIDUAL CONTINUATION OF BENEFITS** section of this booklet, the employer is fulfilling statutory obligations imposed by federal law and, where applicable, acting as your agent.

Conformity with Laws. Any provision of the plan which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Coordination of Benefits

All payments we make are subject to this Coordination of Benefits provision. Coordination of Benefits (COB) is used when you have more than one dental care coverage. This *plan* follows rules established by law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your *family members* are covered by another plan in addition to this one, this *plan* will follow the Coordination of Benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

This *plan* pays for dental care only when you follow its rules and procedures. If its rules conflict with those of another plan, it may be impossible to receive benefits from both plans and you will be forced to choose which plan to use.

Which Plan Is Primary (Order of Benefit Determination Rules)
To decide which plan is primary, you need to consider the coordination of benefits provisions of this *plan*, the other plan, and which member of your family is the patient. The primary plan will be determined by the first of the following rule which applies:

1. **Pediatric Dental Coordination of Benefits.** If pediatric dental Essential Health Benefits are included as part of your medical plan, the medical plan will be the primary coverage for pediatric dental and any dental only plan will be secondary.
2. **Two Dental Plans.** If you have two dental only plans, the plan that includes pediatric dental Essential Health Benefits will be the primary coverage. If neither plan has pediatric dental Essential Health Benefits, the order of benefit determination rules below will apply.
3. **Non-coordinating Plan**
   If the other group plan does not coordinate benefits, then that plan will always be primary.
4. **Subscriber**
   The plan that covers the patient as the *subscriber* is primary to the plan which covers the patient as a dependent.
5. **Dependent Children of Divorced or Separated Parents**
   a. If a court decree makes one parent responsible for dental care coverage, that parent's plan is primary.
   b. If a court decree gives joint custody and does not mention dental care, this plan follows the birthday rule.
   c. If neither of these rules apply, the order will be determined in following order:
      i. The plan of the parent with custody
      ii. The plan of the spouse of the parent with custody

iii. The plan of the parent not having custody

iv. The plan of the spouse of the parent not having custody

6. **Dependent Children**
   The "birthday rule" is used to determine which plan is primary. The plan of the parent with the first birthday in a calendar year is always primary for the children. If the parents' birthdays are the same, then the parent's plan that has been in effect longer is primary. However, if your spouse's plan has some other coordination rule then the rules of that plan will be followed.

7. **Active Group Plan vs. Layoff or Retirement**
   The plan which covers the person as an active employee (or that person's *family member*) is primary to a plan which covers that person as a laid off employee or a retiree (or that person's *family member*).

8. **State or Federal Continuation Coverage**
   When a person's coverage is provided under a right of continuation under federal law (i.e. COBRA) or state law, any other plan covering that person will be primary; unless that plan does not include the same rule.

9. **Length of Time Covered by the Plan**
   The plan which has covered a person for the longer period of time is primary to another plan.

How This Plan Pays When Primary

We do not coordinate benefits for services provided by your *participating dental office*. When we are primary, we will pay for specialty services as if you had no other coverage. You will be responsible to pay for all applicable *copayments*.

How This Plan Pays When Secondary

When we are secondary, we do not coordinate for services provided by your *participating dental office*. However, we will coordinate benefits for specialty services based on your out-of-pocket costs after the primary plan has paid. Payment for specialty services will be the lesser of your out-of pocket costs or what we would have paid if we had been primary. You will be responsible to pay for all applicable *copayments*.

We will pay only for services listed in this Evidence of Coverage. Our payment will be subject to the terms and conditions of this *plan*.

Grievance Procedures

If you are dissatisfied about any aspect of the Anthem Blue Cross Dental services or claim processing or the services or treatment received by a *dentist* participating in the Dental Net network, you may file a grievance verbally by contacting the Customer Service Department toll free telephone number identified on your member ID card or in writing to Anthem Blue Cross Dental Grievances and Appeals, P.O. Box 659471, San Antonio, TX 78265. Also, you may access the company web site at www.anthem.com/ca which provides a method for a member to file a grievance online. All grievances relating to dental care and coverage are referred to the Anthem Dental Grievances and Appeals Department for investigation and response. You may file a grievance for at least 180 days following any incident or action that is the subject of your dissatisfaction. If you need assistance filing a grievance please let your provider or customer service representative know.

Grievance resolution may involve review of your records and x-rays, which, if needed will be requested by the Grievance and Appeals analyst, Dental Director, or dental consultant, utilizing mail, fax or secure email. Grievances will be resolved within thirty (30) calendar days from Anthem's receipt of your expression of dissatisfaction

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved for more than 30 calendar days, you may submit your grievance to the California Department of Managed Health Care for review (see **DEPARTMENT OF MANAGED HEALTH CARE**). If your case involves an imminent threat to your health, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Managed Health Care for review.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-627-0004** or at the TDD/TTY line **711** for the hearing and speech impaired 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

Binding Arbitration

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL or to participate in a class action IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making a written demand on Anthem Blue Cross. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless you or Anthem Blue Cross agrees otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Please send all Binding Arbitration demands in writing to: Anthem Blue Cross, P.O. 659471, San Antonio Texas 78265.

Definitions

The meanings of key terms used in this booklet are shown below. When any of the terms below are italicized in your booklet, you should refer to this section.

Acceptable Service – services and supplies that we determine to be:

- Acceptable and necessary for the diagnosis, prevention, and treatment of your dental condition; and
- Within the community standards of good dental practice.

Agreement – is the Group Benefit Agreement between us and your employer.

Benefit Period – is a 12 month period starting on your group's effective date at 12:01 a.m. Pacific Standard Time.

Copayment – is the amount you will pay for a dental care service. Your copayment amounts are listed under **WHAT IS COVERED: SCHEDULE OF COPAYMENTS**.

Dentist – a licensed dentist that has entered into a contract with us for the Dental Net network.

Effective Date – is the date your coverage begins under this *plan*.

Experimental or Investigative – services that are not recognized and accepted by the American Dental Association (ADA) as standard dental practice.

Family Member – is a person of the *subscriber's* family who is eligible for coverage under the *plan* as described in the **WHO IS COVERED AND WHEN: ELIGIBILITY** section of this booklet.

Group (employer) – is the person, company, corporation, partnership or other entity which has entered into an *agreement* with us to provide the benefits of this *plan*.

Medically Necessary – procedures, supplies, equipment or services that we find to be:

- Appropriate for the symptoms, diagnosis or treatment of a dental condition;
- Provided for the diagnosis or direct care and treatment of the dental condition;
- Within the standards of good dental practice within the organized dental community;
- Not primarily for the convenience of the patient's dentist or other provider;
- The most appropriate procedure, supply, equipment or service that:
    - Has valid scientific evidence showing that the expected health benefits are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications for the patient, than other possible alternatives; and
    - When other generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Member – is any *subscriber* or *family member* covered under this *plan*.

Participating Dental Office – a dental office that has entered into a contract with us for the Dental Net network.

Plan – is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your *group's agreement*, and any attachments.

Specialist – a provider that gives dental care that cannot be performed by your *dentist* and has entered into a contract with us for the Dental Net network.

Subscriber – is the person whose enrollment application has been accepted by us for coverage under this *plan*.

Get Help in Your Language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 TTY/TDD:711 تماس بگیرید.)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li nta wd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਥੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Dental Net®

Plan 3000D

Implant Rider

This Implant Rider changes coverage under your Anthem Blue Cross Certificate of Coverage.

The following benefits are added to the section titled "**What is Covered**" under subsection titled "**Implant Supported Services**".

Your primary care Dentist may decide that you need the care of a specialist for these dental implant procedures. If this happens, your primary care dentist is able to refer you directly to a specialist. You are responsible for paying the copayments listed below for each dental service. For additional information about referrals to a specialist, please refer to your Certificate of Coverage in the subsection titled "**Referral for Specialty Care**".

Procedure Code	RADIOGRAPHIC IMAGES to MONITOR IMPLANT PLACEMENT	Copayment
D0364	**Cone beam CT capture and interpretation with limited field of view - less than one whole jaw** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$155
D0365	**Cone beam CT capture and interpretation with field of view of one full dental arch – mandible** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$150
D0366	**Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$145

D0367	**Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$180
D0380	**Cone beam CT image capture with limited field of view - less than one whole jaw** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$130
D0381	**Cone beam CT image capture with field of view of one full dental arch – mandible** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$180
D0382	**Cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$175
D0383	**Cone beam CT image capture with field of view of both jaws, with or without cranium** – covered one (1) time per sixty (60) month period when submitted with implant placement procedures D6010, D6011, D6012, D6013, D6040 and D6050.	$180
IMPLANT SERVICES		
D6010	**Surgical Placement of Implant Body: Endosteal Implant** - covered once per tooth per sixty (60) month period.	$850
D6011	**Second Stage Implant Surgery** - covered once per tooth per sixty (60) month period is considered included with surgical placement of implant body; endosteal implant.	$135
D6013	**Surgical Placement of Mini Implant** - covered once per tooth per sixty (60) month period.	$340
D6040	**Surgical Placement: Eposteal Implant** - covered once per tooth per sixty (60) month period.	$850
D6050	**Surgical Placement: Transosteal Implant** - covered once per tooth per sixty (60) month period.	$750
D6096	**Remove Broken Implant Retaining Screw** - covered once per tooth per lifetime.	$150
D6100	**Implant Removal, by report**	$255
D6101	**Debridement of Peri-Implant Defect or Defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure** - covered once per tooth per thirty-six (36) month period.	$240

D6102	**Debridement and Osseous Contouring of a Peri-Implant Defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure** - covered once per tooth per thirty-six (36) month period.	$340
D6103	**Bone Graft for Repair of Peri-Implant Defect-does not include flap and closure** - covered once per tooth per thirty-six (36) month period.	$255
D6104	**Bone Graft at Time of Implant Placement** - covered once per tooth per thirty-six (36) month period.	$270
D6190	**Radiographic/Surgical Implant Index, by report** - covered once per tooth per sixty (60) month period lifetime.	$155

Limitations and Exclusions

- Cone Beam images are covered only with implant placement.
- Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Plan and Estimate be completed and reviewed by you and your Dentist prior to treatment.
- Services or supplies that have the primary purpose of improving the appearance of your teeth.
- Interim prosthodontic appliances supported by implants.
- Bone grafts are limited to the time of implant placement and not more than once per tooth per thirty-six (36) months.

This Rider will not change, waive, or extend any part of the Evidence of Coverage, other than as stated above.

Brian Ternan
President California Commercial