California Dental Network

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Group Subscriber Agreement
Combined Evidence of Coverage
And
Disclosure Form

California Dental Network Children's Dental HMO

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

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

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

Applicants may receive additional information about the benefits of the Plan by calling (949) 830-1600, Toll-free (877)433-6825.

The member copayment schedule is located at the end of this Group Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form.

California Dental Network Children's Dental HMO Summary Benefit Matrix

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

Children's Dental HMO	**Child (up to Age 19)**
Deductibles	None
Out of Pocket Maximums	Individual Child- $350
	Two or more Children in a family - $700
Office Copay	No Charge
Waiting Period	None
Annual Benefit Limit	None
Professional Services	Copayments vary by procedure and can be found on the *2017 Member Copayment Schedule,* included. Categories of services include:

Diagnostic & Preventive Services:	Oral Exam	No Charge
	Preventive-Cleaning	No Charge
	Preventive-X-ray	No Charge
	Sealants Per Tooth	No Charge
	Topical Fluoride Application	No Charge
	Space Maintainers, Fixed	No Charge
Basic Services	Restorative Procedures	See *2017 Member Copayment Schedule*
	Periodontal Maintenance Procedures	
	Adult Periodontics (other than maintenance)	
	Adult Endodontics	
Major Services	Periodontics (other than maintenance)	See 2017 Member Copayment Schedule
	Endodontics	
	Crowns and Casts	
	Prosthodontics	
	Oral Surgery	
Orthodontics	Medically Necessary Orthodontia	$350.00

Endnotes to 2017 Dental Standard Benefit Plan Designs

1) Deductible is waived for Diagnostic and Preventive Services.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
4) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
5) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
6) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
7) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

WELCOME

CDN, Inc. (CDN) combines comprehensive dental Coverage with a number of cost-saving features for you and your family. Many preventive procedures are covered at no cost to you, and you will experience significant savings based upon our copayments for covered services. There are no claim forms to complete, and no deductibles or lifetime benefit maximums.

I. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Pocket Maximum (OOPM) means the maximum amount of money that a pediatric age (child up to age 19) enrollee must pay for benefits during a calendar year. Out-of-Pocket Maximum applies only to the Essential Health Benefits for pediatric (children up to age 19) enrollees. Copayments for covered services that pediatric enrollees (children up to age 19) received from a participating dentist accumulate through the plan year toward the Out-of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes premium, prescriptions, or dental care the dental plan doesn't cover. After the pediatric age enrollee reaches their OOPM, they will have no further copayments for benefits for the remainder of the calendar year. If more than one pediatric age enrollee (meaning multiple children in one family) is covered under the contract, the financial obligation for benefits is not more than the OOPM for multiple children. Once the amount paid by all pediatric age enrollees equals the OOPM for multiple pediatric age enrollees, no further copayments will be required by any of the pediatric age enrollees for the remainder of the calendar year.

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

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

Pediatric Dental Benefits are one of the ten Essential Health Benefits required under the Affordable Care Act (ACA). In California, pediatric dental benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

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

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

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

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

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

II. HOW TO USE CDN

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

A complete list of covered services is enclosed in the Benefit Schedule along with the required copayments. Services specifically excluded from Members' Coverage are found in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-panel dentist or specialist are not covered. Under certain emergency situations as explained under the section titled Emergency and Urgent Dental Care, services by a non-contracted general dentist may be covered.

III. ELIGIBILITY

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

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

Coverage Effective Dates:

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

Loss of Medi-Cal or Job-Based Coverage:

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

New Dependent Additions:

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

Newborn and Adoptive Children:

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

Dependent Additions Due to Marriage:

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

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

IV. ELIGIBLE DEPENDENTS

For this plan, a Member's eligible Dependents are their Dependent children. An eligible dependent shall include a) any child born out of wedlock, b) a child not claimed as a dependent on the parents' federal income tax return and c) a child who does not reside with the parent or within the Plan's service area. All newborn infants' Coverage shall commence from and after the moment of birth. Adopted children, stepchildren and foster children shall be covered from and after the date of placement. Except as stated above, Dependents shall be eligible for coverage on the first day of the next month from the date the

Subscriber is eligible for coverage, or on the day the Subscriber acquires such Dependent, whichever is later.

Dependents shall also include all unmarried children up to age 19 who are chiefly dependent on the subscriber for support and maintenance. Coverage shall not terminate while a Dependent child is and continues to be:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the subscriber for support and maintenance provided the subscriber furnishes proof of such incapacity and dependency to CDN within 31 days of the child attaining the limiting age set forth above, and every two years thereafter, if requested by CDN.
- In a case where a parent is required by a court or administrative order to provide coverage for a child the Plan shall not disenroll or eliminate coverage unless a) the employer has eliminated coverage for all employees, b) the Plan is provided with satisfactory written evidence that either the court order or administrative order is no longer in effect, or c) the child is or will be enrolled in another or comparable plan that will take effect no later than the effective date of the child's disenrollment.

V. CHOICE OF PARTICIPATING DENTIST AND PARTICIPATING DENTIST COMPENSATION

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

You may select any CDN Participating Dentist for you and your family's dental care. All family members MUST use the same office and the Plan subscriber must live or work within CDN's service area within California. A request to change dental office may be done by contacting CDN toll-free at 1-877-433-6825 or by requesting such in writing to CDN's office. Any such change will become effective on the first day of the month following CDN's approval if request is received by CDN by the 20th of the month. CDN may require up to 30 days to process any such request. All Member fees and Copayments must be paid in full prior to such a transfer.

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

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

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

VI. SECOND OPINION POLICY

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

General Practice Second Opinion

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

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

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

Members may obtain a second opinion by contacting CDN at 1-877-433-6825. The Member will be given the names of providers in their area to select a second opinion provider. If the Member opts not to accept one of the contracted providers and wishes to go out of the network, it is not a covered benefit. The provider of choice will be notified by the Plan of the Member's need for a second opinion and the applicable co-payment. The Member will be responsible for obtaining an appointment from the second opinion provider.

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

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

- Provide copies of necessary records and radiographs to the Plan (at no charge to the Members, Plan or second opinion provider) for review by the second opinion provider.
- To agree to provide second opinion evaluation to Members at copayment upon approval of the second opinion request by the Plan, and to make the results of their evaluation available to the referring provider, the Member, and the Plan.

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

Specialty Second Opinion

Specialty procedures incorporated in a treatment plan may require a specialty second opinion. These would be processed in the same manner as a general practice second opinion with the same guidelines, except that Members enrolled in Plans without specialty referral benefits will be responsible for the cost of a second opinion from a dental specialist.

Orthodontic Second Opinion

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

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

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

Denials

Conditions under which a second opinion may be denied:

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

Emergency Second Opinion

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

VII. FACILITIES

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

VIII. PREPAYMENT FEE

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

IX. LIABILITY OF MEMBER FOR PAYMENT

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

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

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a participating dental Participating Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide the patient with a treatment plan that includes each anticipated service. If you would like more information about dental coverage options, you may call member services at 1-877-433-6825 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

X. COORDINATION OF BENEFITS

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

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

out-of- pocket cost payable under the primary dental benefit plan for benefits covered under your CDN plan.

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

If the other coverage is a group indemnity plan:

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

If the other coverage is a prepaid plan:

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

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

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

XI. OUT-OF-POCKET MAXIMUM (OOPM)

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

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

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

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

XII. EMERGENCY AND URGENT DENTAL CARE

Emergency and urgent dental care is covered 24 hours a day, seven days a week, for all Members. Emergency dental Care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is care required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefits is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration. Please contact your Participating Dentist for emergency or urgent dental care. If your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-877-433-6825.

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

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

XIII. REIMBURSEMENT PROVISION FOR OUT-OF-AREA CARE

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

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

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

XIV. SPECIALIST REFERRALS

If your Participating Dentist decides that you need the services of a specialist, they will request Prior Authorization for a referral to a CDN Specialist. CDN will send you a letter of treatment authorization, including the name, address, and phone number of your assigned CDN specialist. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by CDN to make the determination. If an emergency referral is required, your Primary Dentist will contact CDN and prompt arrangements will be made for specialty treatment. Emergency referrals are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by CDN to make the determination. Your Primary Dentist will be informed of CDN's decision within 24 hours of the determination. Both the general provider and the patient will be notified in writing of approval or denial. If you have questions about how a certain service is approved, call CDN toll-free at 1-877-433-6825. If you are deaf or hard of hearing, dial 711 for the California Relay Service. We will be happy to send you a general explanation of how that type of decision is made or send you a general explanation of the overall approval process if you request it.

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

XV. CONTINUATION OF COVERAGE ACUTE CONDITION OR SERIOUS CHRONIC CONDITION

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

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

For the purpose of this section:

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

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

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

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

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

XVI. LANGUAGE AND COMMUNICATION ASSISTANCE

If English is not your first language, CDN provides interpretation services and translation of certain written materials. If you have a preferred language, or need language assistance, please notify us of your personal language needs by calling CDN at 877-433-6825.

If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance services by calling CDN at 877-433-6825

XVII. BENEFITS, EXCLUSIONS, AND LIMITATIONS

California Dental Network Covered California Children's Dental HMO Benefits are set forth in the attached list of covered procedures and are subject to the applicable member cost (copayment) in the list, when provided by a CDN Participating Dental Participating Dentist and subject to the Exclusions and Limitations contained herein. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable. Coverage of the pediatric dental essential health benefits is limited to children up to age 19.
Benefits and Limits for Diagnostic Services:

- Periodic oral evaluation (D0120): once every six months, per provider.
- Limited oral evaluation, problem focused (D0140): once per patient per provider.
- Comprehensive oral evaluation (D0150): once per patient per provider for the initial evaluation.
- Detailed and extensive oral evaluation (D0160): problem focused, by repot, once per patient per provider.
- Re-evaluation, limited, problem focused (not post-operative visit) (D0170) : a benefit for the ongoing symptomatic care of temporomandibular joint dysfunction; up to six times in a three month period, up to a maximum of 12 in a 12 month period.
- Radiographs (X-rays), Intraoral, complete series (including bitewings) (D0210): once per provider every 36 months.
- Radiographs (X-rays), Intraoral, periapical first film (D0220): a benefit to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, periapical each additional film (D0230): a benefit to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, occlusal film (D0240): A benefit up to a maximum of two in a six-month period per provider.
- Radiographs (X-rays), Extraoral (D0250): A benefit once per date of service.
- Radiographs (X-rays), bitewing , single film (D0270): A benefit once per date of service.
- Radiographs (X-rays), bitewings, two films (D0272): A benefit once every six months per provider.
- Radiographs (X-rays), bitewings, four films (D0274): A benefit once every six months per provider.
- Radiographs (X-rays), Posterior, anterior, or lateral skull and facial bone survey radiographic image (D0290): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.
- Radiographs (X-rays) Temporomandibular joint arthrogram, including injection (D0320): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.

- Radiographs (X-rays) Tomographic survey (D0322): A benefit twice in a 12 month period per provider.
- Radiographs (X-rays) Panoramic film (D0330): A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
- Radiographs (X-rays), Cephalometric radiographic image (D0340): A benefit twice in a 12 month period per provider.
- Oral/Facial Photographic Images 1st (D0350): A benefit up to a maximum of four per date of service.
- Diagnostic casts (D0470): A benefit once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment, for patients under the age of 21, for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

Benefits and Limits for Preventive Services:

- Prophylaxis, child (D1120): A benefit once in a six- month period for patients under the age of 21.
- Topical fluoride varnish (D1206): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride (D1208), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1208).
- Topical application of fluoride (D1208): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
- Sealant, per tooth (D1351): A benefit, for first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth (D1352): A benefit for first, second and third permanent molars that occupy the second molar position; only for an active cavitated lesion in a pit or fissure that does not cross the DEJ; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Space maintainer, fixed, unilateral (D1510): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral (D1515): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, removable, unilateral (D1520): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires

- Space maintainer, removable, bilateral (D1525): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Re-cementation of space maintainer (D1550): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.

Benefits and Limits for Restorative Services:

- Primary teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 12 month period.
- Permanent teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 36 month period.
- Primary teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 12 month period, each unique tooth surface is only payable once per tooth per date of service.
- Permanent teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 36 month period, each unique tooth surface is only payable once per tooth per date of service
- Primary teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 12 month period.
- Permanent teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 36 month period
- Primary teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 12 month period.
- Permanent teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 36 month period.
- Crown, resin based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2710): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 resin-based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2712): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; or for use as a temporary crown.
- Crown, resin with predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2721): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

- Crown, porcelain/ceramic substrate, permanent anterior and posterior teeth, age 13 or older, (D2740): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain fused to predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2751): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2781): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 porcelain/ceramic, permanent anterior and posterior teeth, age 13 or older, (D2783): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, full cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2791): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Recement inlay, onlay or partial coverage restoration (2910): A benefit once in a 12 month period, per provider.
- Recement crown (D2920): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Prefabricated porcelain/ceramic crown - primary tooth (D2929): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - primary tooth (D2930): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - permanent tooth (D2931): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Primary teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 12 month period.
- Permanent teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Protective restoration (D2940): A benefit once per tooth in a six-month period, per provider. Not a benefit when performed on the same date of service with a permanent restoration or crown, for same tooth; on root canal treated teeth.
- Pin retention - per tooth, in addition to restoration (D2951): A benefit for permanent teeth only; when billed with an amalgam or composite restoration on the same date of service; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp; or for an anterior restoration when extensive coronal destruction involves the incisal angle.

- Post and core in addition to crown, indirectly fabricated (D2952): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Prefabricated post and core in addition to crown (D2954): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Crown repair necessitated by restorative material failure (D2980): A benefit for laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

Benefits and Limits for Endodontic Services:

- Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament (D3220): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; for a primary tooth with a necrotic pulp or a periapical lesion; for a primary tooth that is non-restorable; or for a permanent tooth.
- Pulpal debridement, primary and permanent teeth (D3221): A benefit for permanent teeth or for over-retained primary teeth with no permanent successor; once per tooth.
- Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development (D3222): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Pulpal therapy (resorbable filling) – anterior, primary tooth (D3230), or posterior, primary tooth (D3240), (excluding final restoration): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; or with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
- Root canal therapy, anterior tooth (D3310), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
- •Root canal therapy, bicuspid tooth (D3320), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
- Root canal therapy, molar (excluding final restoration) (D3330): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Retreatment of previous root canal therapy – anterior (D3346), bicuspid (D3347): Not a benefit to the original provider within 12 months of initial treatment.
- Retreatment of previous root canal therapy – molar (D3348): Not a benefit to the original provider within 12 months of initial treatment; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests
- Apexification/ recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.) (D3351): A benefit once per

permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

- Apexification/recalcification – interim (D3352): A benefit once per permanent tooth; only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apicoectomy/periradicular surgery – anterior (D3410): A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - bicuspid (first root) (D3421): A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - molar (first root) (D3425): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apicoectomy / periradicular surgery - molar, each additional root (D3426): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

Benefits and Limits for Periodontic Services:

- Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210) or one to three contiguous teeth, or tooth bounded spaces per quadrant (D4211): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant (D4260): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant (D4261): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Periodontal scaling and root planing - four or more teeth per quadrant (D4341) or one to three teeth per quadrant (D4342): A benefit for patients age 13 or older; each once per quadrant every 24 months.
- Periodontal maintenance (D4910): A benefit only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); only when preceded by a periodontal scaling and root planing (D4341- D4342); only after completion of all necessary scaling and root

planings; once in a calendar quarter; only in the 24 month period following the last scaling and root planing.

- Unscheduled dressing change (by someone other than treating dentist) (D4920): for patients age 13 or older; once per patient per provider; within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)

Benefits and Limits for Prosthodontic Services:

- Prosthodontic services provided solely for cosmetic purposes are not a benefit.
- Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
- Spare or backup dentures are not a benefit.
- Evaluation of a denture on a maintenance basis is not a benefit.
- Complete denture – upper (D5110), lower (D5120): Each a benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
- Immediate denture – upper (D5130), lower (D5140): Each a benefit once per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
- Partial denture - resin based with conventional clasps, rests and teeth, upper (D5211) or lower (D5212): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Partial denture - cast metal resin based with conventional clasps, rests and teeth, upper (D5213) or lower (D5214): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Adjust complete denture - upper (D5410) or lower (D5411): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit: same date of service or within six months of the date of service of a complete denture- maxillary (D5110) mandibular (D5120), immediate denture- maxillary (D5130) mandibular (D5140) or overdenture-maxillary (D5863) or mandibular (D5865); same date of service or within six months of the date of service of a reline complete denture (chairside) maxillary (D5730) mandibular (D5731), reline complete denture (laboratory) maxillary (D5750) mandibular (D5751) and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth- complete denture (D5520).
- Adjust partial denture – upper (D5421), lower (D5422): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit same date of service or within six months of the date of service of: a partial- resin base maxillary (D5211) mandibular (D5212) or partial denture- cast metal framework with resin denture bases maxillary (D5213) mandibular (D5214); same date of service or within six months of the date of service of a reline partial

denture (chairside) maxillary (D5740) mandibular (D5741), reline partial denture (laboratory) maxillary (D5760) mandibular (D5761), and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

- Repair broken complete denture base (D5510): A benefit once per arch, per date of service per provider; twice in a 12-month period per provider. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
- Replace missing or broken teeth - complete denture (each tooth) (D5520): A benefit up to a maximum of four, per arch, per date of service per provider; twice per arch, in a12- month period per provider.
- Repair resin denture base (D5610): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider; for partial dentures only. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
- Repair cast framework (D5620): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider.
- Repair or replace broken clasp (D5630): A benefit up to a maximum of three, per date of service per provider; twice per arch, in a 12- month period per provider.
- Replace broken teeth - per tooth (D5640): A benefit: up to a maximum of four, per arch, per date of service per provider; twice per arch, in a 12- month period per provider; for partial dentures only.
- Add tooth to existing partial denture (D5650): A benefit: for up to a maximum of three, per date of service per provider; once per tooth. Not a benefit for adding 3rd molars.
- Add clasp to existing partial denture (D5660): A benefit: for up to a maximum of three, per date of service per provider; twice per arch, in a 12-month period per provider.
- Reline complete denture (chairside) upper (D5730): a benefit once in a 12-month period; six months after the date of service for an immediate denture- maxillary (D5130)) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
- Reline complete denture (chairside) lower (D5731): Each a benefit once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D58635) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
- Reline partial denture (chairside) upper (D5740): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base maxillary (D5211) or partial

denture- cast metal framework with resin denture bases maxillary (D5213) that required extractions, or 12 months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) maxillary (D5760).

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

(laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761), or same date of service as a prosthesis that did not require extractions.

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

Benefits and Limits for Maxillofacial Prosthetics

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

Benefits and Limits for Implant Services

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

    - skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
    - traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
- Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
- Single tooth implants are not a benefit of the California Dental Network Children's Dental HMO.
- Surgical placement of implant body: endosteal implant (D6010): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
- Surgical placement: eposteal implant (D6040): See D6010
- Surgical placement: transosteal implant (D6050): See D6010
- Connecting bar - implant supported or abutment supported (D6055): See D6010
- Prefabricated abutment - includes modification and placement (D6056): See D6010
- Custom fabricated abutment - includes placement (D6057): See D6010
- Abutment supported porcelain/ceramic crown (D6058): See D6010
- Abutment supported porcelain fused to metal crown (high noble metal) (D6059): See D6010
- Abutment supported porcelain fused to metal crown (predominantly base metal) (D6060): See D6010
- Abutment supported porcelain fused to metal crown (noble metal) (D6061): See D6010
- Abutment supported cast metal crown (high noble metal) (D6062): See D6010
- Abutment supported cast metal crown (predominantly base metal) (D6063): See D6010
- Abutment supported cast metal crown (noble metal) (D6064): See D6010
- Implant supported porcelain/ceramic crown (D6065): See D6010
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) (D6066): See D6010
- Implant supported metal crown (titanium, titanium alloy, high noble metal) (D6067): See D6010
- Abutment supported retainer for porcelain/ceramic FPD (D6068): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal) (D6069): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) (D6070): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (noble metal) (D6071): See D6010
- Abutment supported retainer for cast metal FPD (high noble metal) (D6072): See D6010
- Abutment supported retainer for cast metal FPD (predominantly base metal) (D6073): See D6010
- Abutment supported retainer for cast metal FPD (noble metal) (D6074): See D6010
- Implant supported retainer for ceramic FPD (D6075): See D6010
- Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) (D6076): See D6010

- Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (D6091): See D6010
- Recement implant/abutment supported crown (D6092): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Recement implant/abutment supported fixed partial denture (D6093): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Abutment supported crown (titanium) (D6094): See D6010
- Repair implant abutment, by report (D6095): See D6010

Benefits and Limits for Fixed Prosthodontic Services:

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

- Crown - porcelain/ceramic (D6740): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain fused to predominantly base metal (D6751): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 cast predominantly base metal (D6781): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 porcelain/ceramic (D6783): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - full cast predominantly base metal (D6791): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Recement bridge (D6930): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Fixed partial denture repair necessitated by restorative material failure (D6980): Not a benefit within 12 months of initial placement or previous repair, same provider..

Benefits and Limits for Oral Surgery Services

- Extraction, coronal remnants - deciduous tooth (D7111): Not a benefit for asymptomatic teeth.
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140): Not a benefit to the same provider who performed the initial tooth extraction.
- Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated (D7210): A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
- Removal of impacted tooth - soft tissue (D7220): A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
- Removal of impacted tooth - partially bony (D7230): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
- Removal of impacted tooth - completely bony (D7240): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.
- Removal of impacted tooth - complete bony with unusual surgical complications (D7241): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
- Surgical removal of residual tooth roots (cutting procedure) (D7250): A benefit when the root is completely covered by alveolar bone. Not a benefit to the same provider who performed the initial tooth extraction.

- Oral Antral Fistula Closure (D7260): A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity. Not a benefit in conjunction with extraction procedures (D7111 – D7250).
- Primary closure of a sinus perforation (D7261): A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.
- Tooth reimplantation and/ or stabilization of accidentally evulsed or displaced tooth (D7270): A benefit once per arch regardless of the number of teeth involved, and for permanent anterior teeth only.
- Surgical access of an unerupted tooth (D7280): Not a benefit for 3rd molars.
- Placement of device to facilitate eruption of impacted tooth (D7283): A benefit only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Biopsy of oral tissue - hard (bone, tooth) (D7285): A benefit for the removal of the specimen only; once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Biopsy of oral tissue – soft (D7286): A benefit for the removal of the specimen only; up to a maximum of three per date of service. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Surgical repositioning of teeth (D7290): A benefit for permanent teeth only; once per arch; only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Transseptal fiberotomy/supra crestal fiberotomy, by report (D7291): A benefit once per arch; only for patients in active orthodontic treatment.
- Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7310): Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.
- Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7320): A benefit regardless of the number of teeth or tooth spaces. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.
- Vestibuloplasty – ridge extension (secondary epithelialization) (D7340): A benefit once in a five year period per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch; on the same date of service with extractions (D7111-D7250) same arch.
- Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (D7350): A benefit once per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; on the same date of service with extractions (D7111- D7250) same arch.

- Excision of benign lesion, complicated (D7412): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Excision of malignant lesion, complicated (D7415): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Removal of lateral exostosis (maxilla or mandible) (D7471): A benefit once per quadrant; for the removal of buccal or facial exostosis only.
- Removal of Torus Palatinus (D7472): A benefit once in the patient's lifetime.
- Removal of torus mandibularis (D7473): A benefit once per quadrant.
- Surgical reduction of osseous tuberosity (D7485): A benefit once per quadrant.
- Incision and drainage of abscess - intraoral soft tissue (D7510): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces). (D7511): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue (D7530): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Removal of reaction producing foreign bodies, musculoskeletal system (D7540): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111- D7250).
- Partial ostectomy /sequestrectomy for removal of non-vital bone (D7550): A benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a benefit within 30 days of an associated extraction (D7111-D7250).
- Maxillary sinusotomy for removal of tooth fragment or foreign body (D7560): Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7680): A benefit for the treatment of simple fractures.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7780): A benefit for the treatment of compound fractures.
- Occlusal orthotic device, by report (D7880): A benefit for diagnosed TMJ dysfunction. Not a benefit for the treatment of bruxism.
- Unspecified TMD therapy, by report (D7899): Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis
- Suture of recent small wounds up to 5 cm (D7910): Not a benefit for the closure of surgical incisions.
- Complicated suture – up to 5 cm (D7911): Not a benefit for the closure of surgical incisions.
- Complicated suture – greater than 5 cm (D7912): Not a benefit for the closure of surgical incisions.
- Skin graft (identify defect covered, location and type of graft) (D7920): Not a benefit for periodontal grafting.

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

Benefits and Limits for Orthodontic Services

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:
    - cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - a deep impinging overbite in which the lower incisors are destroying the soft tissue of

the palate,

- a crossbite of individual anterior teeth causing destruction of soft tissue,
- an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
- a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

- Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion (D8080): A benefit for handicapping malocclusion, cleft palate and facial growth management cases; for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per patient per phase of treatment.
- Removable appliance therapy (D8210): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Fixed appliance therapy (D8220): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Pre-orthodontic treatment visit (D8660): A benefit prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three months; for patients under the age of 21; for a maximum of six.
- Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion (D8670): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter.
- The maximum quantity of monthly treatment visits for the following phases are:
- Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Cleft Palate:
        - Primary dentition– up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Facial Growth Management:
        - Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

        - Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
- Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (D8680): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per arch for each authorized phase of orthodontic treatment.
- Repair of orthodontic appliance (D8691): A benefit for patients under the age of 21; once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
- Replacement of lost or broken retainer (D8692): A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention (D8680).
- Rebonding or recementing: and/or repair, as required, of fixed retainers (D8693): A benefit for patients under the age of 21; once per provider.

Benefits and Limits for Adjunctive Services

- Palliative (emergency) treatment of dental pain - minor procedure (D9110): A benefit once per date of service per provider regardless of the number of teeth and/or areas treated. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Fixed partial denture sectioning (D9120): A benefit when at least one of the abutment teeth is to be retained.
- Local anesthesia not in conjunction with outpatient surgical procedures (D9210): A benefit once per date of service per provider, only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Deep sedation/general anesthesia - each 15 minute increment (D9223): Not a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9241 and D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Analgesia nitrous oxide (D9230): A benefit for uncooperative patients under the age of 13, or for patients age 13, or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9241 and D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.

- Intravenous moderate (conscious) sedation/analgesia - first 30 minutes (D9241): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment (D9243): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Non-intravenous conscious sedation (D9248): A benefit for uncooperative patients under the age of 13, or for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration; once per date of service. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9241 and D9243); when all associated procedures on the same date of service by the same provider are denied.
- House/Extended care facility call (D9410): A benefit once per patient per date of service; only in conjunction with procedures that are payable.
- Hospital or ambulatory surgical center call (D9420): A benefit for each hour or fraction thereof as documented on the operative report. Not a benefit: for an assistant surgeon; for time spent compiling the patient history, writing reports or for post- operative or follow up visits.
- Office visit for observation (during regularly scheduled hours) - no other services performed (D9430): A benefit once per date of service per provider. Not a benefit when procedures other than necessary radiographs and/or photographs are provided on the same date of service; for visits to patients residing in a house/ extended care facility.
- Office visit - after regularly scheduled hours (D9440): A benefit once per date of service per provider; only with treatment that is a benefit.
- Therapeutic parenteral drug, single administration (D9610): A benefit for up to a maximum of four injections per date of service. Not a benefit for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9241 and D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Application of desensitizing medicament (D9910): A benefit once in a 12-month period per provider; for permanent teeth only. Not a benefit when used as a base, liner or adhesive under a restoration; the same date of service as fluoride (D1206 and D1208).
- Treatment of complications (post-surgical) - unusual circumstances, by report (D9930): A benefit once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; for the removal of bony fragments within 30 days of the date of service of an extraction. Not a benefit for the removal of bony fragments on the same date of service as an extraction; for routine post- operative visits.

- Occlusion analysis – mounted case (D9950): A benefit once in a 12-month period; for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition. Not a benefit for bruxism only.
- Occlusal adjustment – limited (D9951): A benefit once in a 12-month period per quadrant per provider; for patients age 13 or older; for natural teeth only. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.
- Occlusal adjustment – complete (D9952): A benefit once in a 12-month period following occlusion analysis- mounted case (D9950); for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition.

XVIII. RENEWAL,CHANGES, AND TERMINATION

How Does CDN Coverage Renew?
Your coverage will be automatically renewed at the same terms and conditions unless CDN notifies you in writing at least 30 days before the end of your coverage term describing any changes in the premium, coverage or other terms or conditions of your coverage
Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after sixty (60) calendar days' notice to the Subscriber's address of record with CDN.

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

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

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

Your membership with CDN will terminate if you:

- No Longer Meet Eligibility Requirements: Your employer or group no longer subscribes to California Dental Network for dental coverage. If this happens, you will receive notice through your employer or group administrator at least 30 days before the change takes

effect. Coverage for your Dependents will also end. You no longer meet age or other eligibility requirements for coverage under this product as required by CDN or Covered California. Your CDN Plan coverage may also end if your job ends or you no longer work enough hours to be on your employer's plan. In this case coverage for your Dependents also ends. You no longer live or work in CDN's Service Area for this product. Fraud or Misrepresentation: you commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of your coverage with CDN, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed. Some examples include:

- Misrepresenting eligibility information.
- Presenting an invalid prescription or physician order.
- Misuse a CDN Member ID Card (or letting someone else use it).

Termination Notice

Upon termination of this Agreement, CDN will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

If you claim that we ended the Member's right to receive Covered Services because of the Member's health status or requirements for health care services, you may request a review. To request a review call the Department of Managed Health Care by calling toll-free at 1 (800) 400-0815.
Either CDN or the member may cancel this Subscriber Agreement if any party breaches the terms or conditions of this Subscriber Agreement. Health plan termination shall be effective the last day of the month in which the termination of this Subscriber Agreement occurs.
Should this Group Subscriber Agreement be terminated because the Subscriber hasn't remitted to CDN any fees owed, and then pays CDN by the date the next payment is due, this Subscriber Agreement will be automatically reinstated as if never terminated.

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

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

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

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

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

A. COBRA

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

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

Important deadlines for electing/enrolling in COBRA with CDN:

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

1. Notification of qualifying event:
   Employers must notify CDN within 30 days after the following qualifying events:
   - The employee's job ends
   - The employee's hours of employment are reduced
   - The employee becomes eligible to receive Medicare Benefits
   - The employee dies

   You or your Dependent must notify CDN in writing within 60 days after any of the following qualifying events:
   - The employee divorces or legally separates
   - A child or other Dependent no longer qualifies as a Dependent under plan rules

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

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

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

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

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

You will lose COBRA if:

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

B. Cal-COBRA
Cal-COBRA is a California law that applies to Employers who have between 2 and 19 employees in their group health plan.

- Cal-COBRA may allow you, your Dependents, and former Dependents to keep CDN coverage for up to 36 months.
- You have the same Benefits as current Members with CDN coverage.
- You have to pay all of the monthly premium.

Important deadlines for electing/enrolling in Cal-COBRA with CDN:
It is important to meet the following deadlines. If you do not, you lose your right to Cal-COBRA coverage.

1. Notification of qualifying event: Employers must notify CDN within 30 days after the following qualifying events:
    - The employee's job ends
    - The employee’s hours of employment are reduced

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

- The employee dies

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

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

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

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

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

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

You will lose Cal-COBRA if:

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

XX. COMPLAINTS, DISPUTES AND GRIEVANCES

Any complaint you may have should initially be brought to the attention of your Participating Dentist. If it is not resolved to your satisfaction, you are encouraged to contact CDN. Any information, inquiries, complaints or disputes regarding any problems that are encountered while obtaining services should be made to CDN. Complaint forms as well as a copy of CDN's Grievance Procedures are available upon

request. Member complaints or grievances can be made in person, at any Participating Dentist's office or by obtaining a Grievance Form from CDN by writing, faxing or calling CDN as follows, or by visiting the website at www.caldental.net:

California Dental Network, Inc.
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
Phone (949) 830-1600: Toll-Free (877) 433-6825
Fax (949) 830-1655

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

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at 1-949-830-1600 or toll-free 1-877-433-6825 and use your Health Plan's grievance process before contacting the Department. For the hearing and speech impaired, dial 711 to call with the Telecommunications Relay Service. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process

will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. **The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.**

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

Health Plan Linguistic and Cultural Policy Regarding Grievances

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

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

XXI. BINDING ARBITRATION

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

XXII. DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

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

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

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

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

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

XXIII. ADDITIONAL INFORMATION

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

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

XXIV. ORGAN AND TISSUE DONATION

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

XXV. GENERAL PROVISIONS

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

Agreement, it shall supersede the applicable provisions of this Agreement and shall be binding unto the parties hereto.

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

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

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

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

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

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

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

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

XXVI. INDEPENDENT MEDICAL REVIEW

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-877-433-6825) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.