California Dental Network
A DentaQuest company

Principal Benefits & Coverage
Plan 595

- These procedures are covered benefits only when provided by a participating General Dentist, and they are subject to Plan limitations, exclusions and guidelines.
- Members must select, and be assigned to, a CDN plan contracted dental office to utilize covered benefits.
- Member Co-payments are payable to the dental office at the time of services.
- This schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- Dental procedures not listed are available at the dental office's usual and customary fee.
- Please see the attached Cosmetic Benefits Rider for fees for popular upgrades to many covered procedures

CODE	DESCRIPTION	MEMBER COPAYMENT
DIAGNOSTIC SERVICES		
ALL RADIOGRAPHS AND ALL DIAGNOSTIC IMAGES INCLUDE READING AND INTERPRETATION BY ANY CONTRACTING PROVIDER. CONTRACTED DENTISTS MAY NOT CHARGE A SURCHARGE TO INTERPRET DIAGNOSTIC IMAGES.		
	Office Visit (includes infection control)	$0.00
D0120	Periodic oral evaluation	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused	$0.00
D0171	Re-evaluation - post operative visit	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$15.00
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical first image	$0.00
D0230	Intraoral - periapical each additional image	$0.00
D0240	Intraoral - occlusal image	$0.00
D0270	Bitewing - single image	$0.00
D0272	Bitewings - two images	$0.00
D0273	Bitewings, 3 images	$0.00
D0274	Bitewings - four images	$0.00
D0330	Panoramic image	$0.00
D0350	2D Oral/facial photographic images, non-orthodontic, obtained intraorally or extraorally	$0.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts, non-orthodontic	$10.00
D0601	Caries risk assessment and documentation, with a finding of low risk	$0.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0.00
D0603	Caries risk assessment and documentation, with a finding of high risk	$0.00
PREVENTIVE SERVICES		
# - PROCEDURES LIMITED TO ONCE EVERY 6 MONTHS, COVERED ONLY AT THE GENERAL DENTIST'S OFFICE.		
+ - LIMITED TO ONE EVERY 12 MONTHS ON ALL BASIC PLANS.		
D1110	Prophylaxis - adult #	$0.00
D1120	Prophylaxis - child #	$0.00
D1206	Topical Fluoride Varnish -children to age 14 Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish-children to age 14	$0.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth	$5.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$5.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18 mos of initial placement.	$5.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$5.00
D1510	Space maintainer - fixed - unilateral	$45.00
D1516	Space Maintainer, Fixed, mandibular.	$45.00

Principal Benefits & Coverage Plan 595

D1517	Space Maintainer, Fixed, maxillary.	$45.00
D1520	Space maintainer - removable - unilateral	$45.00
D1526	Space Maintainer, removable, maxillary.	$45.00
D1527	Space Maintainer, removable, mandibular.	$45.00
D1550	Recement or rebond space maintainer	$10.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$45.00

RESTORATIVE SERVICES

INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.

D2140	Amalgam - 1 surface, primary or permanent	$4.00
D2150	Amalgam - 2 surfaces, primary or permanent	$5.00
D2160	Amalgam - 3 surfaces, primary or permanent	$6.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$8.00
D2330	Resin-based composite - 1 surface, anterior	$14.00
D2331	Resin-based composite - 2 surfaces, anterior	$14.00
D2332	Resin-based composite - 3 surfaces, anterior	$14.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$16.00
D2390	Resin-based composite crown, anterior	$18.00
D2391	Resin-based composite - 1 surface, posterior. Covered for Facial surfaces of Bicuspids Only, when Caries or Failing Restoration Exists.	$18.00

INLAYS/ONLAYS

INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION; MEMBER IS RESPONSIBLE FOR LAB COST OF GOLD/NOBLE/HIGH NOBLE METAL.

D2510	Inlay - metallic - 1 surface	$70.00
D2520	Inlay - metallic - 2 surfaces	$70.00
D2530	Inlay - metallic - 3 or more surfaces	$90.00
D2542	Onlay - metallic - 2 surfaces	$120.00
D2543	Onlay - metallic - 3 surfaces	$120.00
D2544	Onlay - metallic - 4 or more surfaces	$120.00

CROWNS

INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION; MEMBER IS RESPONSIBLE FOR LAB COST OF GOLD/NOBLE/HIGH NOBLE METAL.

*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.

D2710	Crown - resin-based composite (indirect)	$105.00
D2720	Crown - resin with high noble metal	$156.00
D2721	Crown - resin with predominantly base metal	$156.00
D2722	Crown - resin with noble metal	$156.00
D2750	Crown - porcelain fused to high noble metal	$156.00
D2751	Crown - porcelain fused to predominantly base metal	$156.00
D2752	Crown - porcelain fused to noble metal	$156.00
275MLR	Crown-porcelain fused to any metal for molars	$236.00
D2780	Crown - 3/4 cast high noble metal	$142.00
D2781	Crown - 3/4 cast predominantly base metal	$142.00
D2782	Crown - 3/4 cast noble metal	$142.00
D2790	Crown - full cast high noble metal	$142.00
D2791	Crown - full cast predominantly base metal	$142.00
D2792	Crown - full cast noble metal	$142.00
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$20.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations.	$10.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$10.00
D2920	Recement or rebond crown	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	$17.00
D2931	Prefabricated stainless steel crown - permanent tooth	$17.00
D2940	Sedative filling	$5.00
D2941	Interim therapeutic restoration-primary dentition	$5.00
D2949	Restorative foundation for an indirect restoration	$0.00
D2950	Core buildup, including any pins when required*	$0.00
D2951	Pin retention - per tooth, in addition to restoration*	$5.00
D2952	Indirectly fabricated post and core in addition to crown*	$65.00
D2953	Each additional indirectly fabricated post - same tooth*	$0.00

Principal Benefits & Coverage Plan 595

D2954	Prefabricated post and core in addition to crown*	$35.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2990	Resin infiltration of incipient smooth surface lesions.	$5.00

ENDODONTICS (EXCLUDING FINAL RESTORATIONS)

INCLUDES ALL IRRIGANTS, DISINFECTANTS, INTRACANAL MEDICAMENTS, ADHESIVES, AND FILLING MATERIALS, REMOVAL OF EXISTING RESTORATIONS, RUBBER DAM PLACEMENT, AND POST-TREATMENT TEMPORIZATION.
*COVERED ONLY AT GP OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM

D3110	Pulp cap - direct	$5.00
D3120	Pulp cap - indirect	$12.00
D3220	Therapeutic pulpotomy	$12.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$15.00
D3310	Root canal - anterior per tooth	$80.00
D3320	Root canal - premolar, per tooth	$100.00
D3330	Root canal - molar tooth, per tooth	$140.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70% of UCR*
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$25.00
D3346	Retreatment of previous root canal therapy - anterior	$180.00
D3347	Retreatment of previous root canal therapy - premolar	$200.00
D3348	Retreatment of previous root canal therapy - molar	$240.00
D3410	Apicoectomy - anterior	$60.00
D3421	Apicoectomy- bicuspid (first root)	$60.00
D3425	Apicoectomy- molar (first root)	$60.00
D3426	Apicoectomy-(each additional root)	$60.00
D3427	Periradicular surgery without apicoectomy	$60.00
D3430	Retrograde filling - per root	$40.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$0.00

PERIODONTICS

- COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.
* - PROCEDURES LIMITED TO ONCE EVERY 6 MONTHS
+-THE PLAN CONSIDERS GINGIVECTOMY PROVIDED IN ASSOCIATION WITH ANY DIRECT FILL RESTORATION TO BE INCLUDED IN THE FEE FOR THE RESTORATION.

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth per quadrant	$100.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$90.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$45.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$100.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$90.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	70% of UCR*
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	70% of UCR*
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$150.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$100.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant #	$30.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation *, #	$0.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Not to be completed on same day as D0150, D0160, or D0180. Must be followed by a separate, subsequent treatment visit (D1120, D1110, D4142/D4143, D4346, D4910) or will be considered by plan to be D1110/D1120)	$10.00
D4910	Periodontal maintenance - once every 6 months	$15.00
D4910	Periodontal maintenance - each additional	$15.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00

REMOVABLE PROSTHODONTICS

EXCEPT WHEN NOTED, INCLUDES ALL LAB COSTS AND POST DELIVERY ADJUSTMENTS FOR 6 MONTHS FOLLOWING DELIVERY. REPLACED ONCE EVERY 5 YEARS FROM INITIAL PLACEMENT UNDER PLAN COVERAGE & RELINED ONCE EVERY 24 MONTHS, AS PER LIMITATIONS, EXCLUSIONS, AND GUIDELINES.

D5110	Complete upper denture	$160.00
D5120	Complete lower denture	$160.00
D5130	Immediate upper denture	$160.00

Principal Benefits & Coverage Plan 595

D5140	Immediate lower denture	$160.00
D5211	Upper partial denture - resin base	$150.00
D5212	Lower partial denture - resin base	$150.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$175.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$175.00
D5221	Immediate maxillary partial denture - resin base	$150.00
D5222	Immediate mandibular partial denture - resin base	$150.00
D5223	Immediate maxillary partial denture - metal framework	$175.00
D5224	Immediate maxillary partial denture - metal framework	$175.00
D5410	Adjust complete denture - upper	$0.00
D5411	Adjust complete denture - lower	$0.00
D5421	Adjust partial denture - upper	$0.00
D5422	Adjust partial denture - lower	$0.00
D5511	Repair broken complete denture base, mandibular.	$15.00
D5512	Repair broken complete denture base, maxillary.	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$17.00
D5611	Repair resin denture base, mandibular.	$15.00
D5612	Repair resin denture base, maxillary.	$15.00
D5621	Repair cast partial framework, mandibular.	$17.50
D5622	Repair cast partial framework, maxillary.	$17.50
D5630	Repair or replace broken clasp	$17.50
D5640	Replace partial denture broken teeth - per tooth	$17.50
D5650	Add tooth to existing partial denture	$17.50
D5660	Add clasp to existing partial denture	$17.50
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$60.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$60.00
D5730	Reline complete upper denture (chairside)	$20.00
D5731	Reline complete lower denture (chairside)	$20.00
D5740	Reline upper partial denture (chairside)	$20.00
D5741	Reline lower partial denture (chairside)	$20.00
D5750	Reline complete upper denture (laboratory)	$42.00
D5751	Reline complete lower denture (laboratory)	$42.00
D5760	Reline upper partial denture (laboratory)	$42.00
D5761	Reline lower partial denture (laboratory)	$42.00
D5820	Interim partial denture (upper)	$90.00
D5821	Interim partial denture (lower)	$90.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	

IMPLANT SERVICES

INCLUDES LAB COSTS, TEMPORIZATION, AND REMOVAL OF EXISTING RESTORATIONS. MEMBER IS RESPONSIBLE FOR LAB COST OF GOLD/NOBLE/HIGH NOBLE METAL.

IMPLANTS ARE A COVERED BENEFIT ONLY FOR INDIVIDUALS ON THE CALIFORNIA DENTAL NETWORK PLAN 595 AND ARE COVERED SERVICES ONLY WHEN PERFORMED BY A CONTRACTED GENERAL DENTIST.

D6010	Surgical placement of implant body, endosteal; includes cost of, and placement of, healing cap when indicated.	$1,500.00
D6056	Prefabricated abutment, includes placement	$450.00
D6058	Abutment supported porcelain/ceramic crown	$1,055.00
D6059	Abutment supported porcelain/high noble crown	$1,050.00
D6060	Abutment supported porcelain/base metal crown	$1,000.00
D6061	Abutment supported porcelain/noble metal crown	$1,050.00
D6062	Abutment supported cast metal crown, high noble	$1,050.00
D6063	Abutment supported cast metal crown, base metal	$900.00
D6064	Abutment supported cast metal crown, noble metal	$950.00
D6065	Implant supported porcelain/ceramic crown	$990.00
D6066	Implant supported porcelain/metal crown	$970.00
D6067	Implant supported metal crown	$935.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. This procedure is not to be performed on the same day as D1110, D4346, or D4910.	$25.00
D6085	Provisional implant crown	$0.00
D6092	Recement implant/abutment supported crown	$45.00
D6094	Abutment supported crown, titanium	$640.00

Principal Benefits & Coverage Plan 595

FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION. MEMBER IS RESPONSIBLE FOR LAB COST OF GOLD/NOBLE/HIGH NOBLE METAL.		
D6210	Pontic - cast high noble metal	$142.00
D6211	Pontic - cast predominantly base metal	$142.00
D6212	Pontic - cast noble metal	$142.00
D6240	Pontic - porcelain fused to high noble metal	$156.00
D6241	Pontic - porcelain fused to predominantly base metal	$156.00
D6242	Pontic - porcelain fused to noble metal	$156.00
624MLR	Pontic- porcelain fused to any metal for molars	$236.00
D6250	Pontic - resin with high noble metal	$156.00
D6251	Pontic - resin with predominantly base metal	$156.00
D6252	Pontic - resin with noble metal	$156.00
D6253	Provisional Pontic- When final impression not taken and when replacing anterior tooth lost or anterior prosthesis being replaced while covered by CDN	$15.00
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION; MEMBER IS RESPONSIBLE FOR LAB COST OF GOLD/NOBLE/HIGH NOBLE METAL.		
D6602	Inlay - cast high noble metal, 2 surfaces	$70.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$90.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$70.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$90.00
D6606	Inlay - cast noble metal, 2 surfaces	$70.00
D6607	Inlay - cast noble metal, 3 or more surface	$90.00
D6610	Onlay - cast high noble metal, 2 surfaces	$120.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$120.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$120.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$120.00
D6614	Onlay - cast noble metal, 2 surfaces	$120.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$120.00
D6720	Crown - resin with high noble metal	$156.00
D6721	Crown - resin with predominantly base metal	$156.00
D6722	Crown - resin with noble metal	$156.00
D6750	Crown - porcelain fused to high noble metal	$156.00
D6751	Crown - porcelain fused to predominantly base metal	$156.00
D6752	Crown - porcelain fused to noble metal	$156.00
675MLR	Crown-porcelain fused to any metal for Molars	$236.00
D6780	Crown - 3/4 cast high noble metal	$142.00
D6781	Crown - 3/4 cast predominantly base metal	$142.00
D6782	Crown - 3/4 cast noble metal	$142.00
D6790	Crown - full cast high noble metal	$142.00
D6791	Crown - full cast predominantly base metal	$142.00
D6792	Crown - full cast noble metal	$142.00
D6793	Provisional retainer crown - When final impression not taken and when replacing anterior tooth lost or anterior prosthesis being replaced while covered by CDN	$15.00
D6930	Recement or rebond fixed partial denture	$0.00
D6980	Fixed partial denture repair, necessitated by restorative material failure. Not allowed to be charged by same provider within 24 months of the original restoration	$50.00
ORAL SURGERY		
INCLUDES SUTURES AND CLOTTING AGENTS; EXTRACTIONS INCLUDE MINOR SMOOTHING OF BONE.		
D7111	Extraction, coronal remnants - primary tooth	$10.00
D7140	Extraction, erupted tooth or exposed root	$10.00
D7210	Surgical removal of erupted tooth	$30.00
D7220	Removal of impacted tooth - soft tissue	$40.00
D7230	Removal of impacted tooth - partially bony	$50.00
D7240	Removal of impacted tooth - completely bony	$75.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$75.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$30.00
D7251	Coronectomy - intentional partial tooth removal	$75.00
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$70.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$70.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$80.00

Principal Benefits & Coverage Plan 595

D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$80.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$14.00
ORTHODONTICS (ONLY WHEN PROVIDED BY PARTICIPATING ORTHODONTIST)		
* - COVERED FOR UP TO 24 MONTHS OF ACTIVE TREATMENT		
D8020	Limited orthodontic treatment of the transitional dentition*	$1,000.00
D8030	Limited orthodontic treatment of the adolescent dentition*	$1,000.00
D8040	Limited orthodontic treatment of the adult dentition*	$1,000.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,695.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,695.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$1,695.00
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$40.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	$150.00
D8681	Removable orthodontic retainer adjustment	$0.00
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	$25.00
D8999	Orthodontic Treatment Plan and Records(pre/post x-rays, photos, study models)	UCR*
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit. Orthodontists may charge Members additional fees for costs of cases over 24 months, based on the differences in UCR fees for the needed treatment periods less the UCR fees for a 24 month period.	See Code Description.
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$5.00
D9120	Sectioning of fixed partial denture (bridge)	$25.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0.00
D9215	Local anesthesia	$0.00
D9310	Consultation & Second Opinion, **with prior authorization from Plan**. Diagnostic service provided by dentist or physician other than requesting dentist or physician, not chargeable on same day as therapeutic services.	$10.00
D9311	Consultation with a medical health care professional	$0.00
D9430	Office visit for observation (during regularly scheduled hours)	$0.00
D9440	Office visit - after regularly scheduled hours	$10.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$10.00
D9951	Occlusal adjustment - limited	$0.00
D9961	duplicate/copy patient's records	$25.00
D9986	Missed appointment	$25.00
D9987	Cancelled appointment	$25.00
D9990	certified translation or sign-language services per visit. Contact the Plan to arrange services at no charge to member or provider	$0.00
D9995	teledentistry – synchronous; real-time encounter#	$0.00
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review#	$0.00
D9999	Broken Appointment - less than 24 notice	$30.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

*UCR=Usual, Customary and Reasonable Fees

Specialty Coverage:

595 Not all general dentists are capable of performing each of the services listed herein and, based upon the Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such cases, once approved by the Plan, the Member will be referred to a contracted dental specialist. The participating contracted dental specialist will provide Members the covered services listed above at a 30% discount from the participating specialist's UCR fees for the first year, and a 50% discount thereafter, for up to $1,000 in covered, approved, UCR services per year; and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in UCR services per Member, per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

Principal Benefits & Coverage Plan 595

EXCLUSIONS AND LIMITATIONS

The Plan's basic Limitations and Exclusions are applicable to all basic plan designs (Individual Plans 100 to 695, and UABT plans). Some limitations and exclusions are waived for Members on Plans with the Cosmetic Benefits Rider. Please see the Plan Clinical Guidelines for specific policies.

EXCLUSIONS

- Treatment of fractures or dislocations; congenital malformations; malignancies, cysts, or neoplasms; or Temporomandibular Joint Syndrome (TMJ).
- Extractions or x-rays for orthodontic purposes.
- Prescription Drugs and over the counter medicines.
- Any services involving implants or experimental procedures.
- Any procedures performed for cosmetic, elective or aesthetic purposes
- Any procedure to replace or stabilize tooth structure lost by attrition, abrasion, erosion or grinding.
- Any procedure not specifically listed as a covered Benefit.
- Services provided outside the CDN Participating General Dentist's office that the Member selected, or was assigned, to receive covered services, unless expressly authorized by CDN.
- Services, which in the opinion of the attending CDN dentist, cannot be performed in the dental office due to the general health and/or physical or behavioral limitations of the Member.
- Services for injuries or conditions, which were caused by acts of war, or are covered under Worker's Compensation or Employer's Liability Laws.
- Services which in the opinion of the attending CDN dentist are not necessary for the Member's dental health or which have a poor prognosis.
- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

Principal Benefits & Coverage Plan 595

- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Services of a specialist are covered Benefits only when specifically listed, and when covered, Pedodontic referral and services are covered at 50% of the pedodontist's fees.
- Optional Treatment – If (1) a less expensive alternative procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition, as determined by the Plan; and (2) the alternate treatment will produce a professionally satisfactory result; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.
- Crowns are limited to five per arch per year.

ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR ORTHODONTICS

- Orthodontic treatment must be rendered by a participating CDN Orthodontist and the Member must remain eligible throughout the period of active orthodontic treatment. Members losing eligibility during treatment will be charged the treating Orthodontist's usual and customary fees for any unfinished treatment.
- Orthodontic Benefits are for 24 months of active treatment. Treatment in excess of 24 months (extended treatment) is available at the participating CDN Orthodontist's usual and customary fees. Members whose treatment is extended because of gross non-compliance or who change Providers while in active treatment will incur additional charges.
- Unless specifically listed in the Summary of Benefits, the following are not covered Benefits under this Evidence of Coverage and Disclosure Form:
    - Study Models and Initial Diagnostic Work-up
    - X-rays for Orthodontic Purposes
    - Tracings and Photographs
    - Extractions for Orthodontic purposes
    - Phase I Orthodontic Treatment
- The following are not included as an orthodontic Benefit:
    - Replacement or repair of lost or broken appliances,
    - Re-treatment of orthodontic cases,
    - Treatments started or in progress prior to a Member's eligibility,
    - Changes in treatment necessitated by an accident,
    - Orthodontic treatment that involves:
        - Maxillofacial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia,
        - Surgically exposing impacted teeth (i.e., Maxillary cuspids),
        - Hormonal imbalances or other factors causing growth and development abnormalities,
    - Treatment related to temporomandibular joint disturbances (TMJ),
    - Lingually placed direct bonded appliances and arch wires - "invisible braces",
    - Cases involving surgical orthodontics,
    - Severe or mutilated malocclusions.
    - Treatment using plastic aligners (i.e. Invisalign®, Clear Correct®, Red White & Blue®).

Principal Benefits & Coverage Plan 595

ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR IMPLANTS

Implants are a **covered benefit only for Individuals on the California Dental Network Plan 595 and are covered services ONLY when performed by a contracted General Dentist.**

- All covered services are subject to eligibility and dental necessity at the time of service, and must be recommended by the dentist.
- Implant Services are a covered benefit when performed by a **contracted General Dentist only**, not all General Dentists provide implant services, and not all implants can be placed by General Dentists.
- Implants are limited to no more than once for the same tooth position in a five (5) year period.
- Implants and Implant abutments are limited to no more than two (2) each per year.
- Dental procedures not listed are available at the dental office's usual and customary fee.

If you question a course of treatment, a fee, or covered benefits, DO NOT START TREATMENT until you have contacted Member Services toll-free at 1-877-433-6825 or a review of your treatment plan and charges. Or a second opinion may be arranged by Member Services only before treatment is rendered.

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