GUIDELINES FOR GENERAL DENTISTS

California Dental Network

A DentaQuest company

CONTACT INFORMATION

Provider Services
California Dental Network
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653
877-433-6825 Ext 1201
Provider Services E-mail: Provider.relations@caldental.net
Provider Services Fax: 949-398-0041
Claims Questions E-mail:cdnclaims@caldental.net
Claims/Accounting issues: 714-242-7458

Customer Service/Member Services
CALIFORNIA DENTAL NETWORK: 855-425-4164

Request for Authorizations should be sent to:
CALIFORNIA DENTAL NETWORK - Authorizations
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653

Credentialing
CALIFORNIA DENTAL NETWORK:
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
877-433-6825 ext 1242

CLAIMS SUBMISSION

Paper Claims should be sent to:
CALIFORNIA DENTAL NETWORK- Claims
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653
Fax: 657-235-0145

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Benefits

California Dental Network

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INTRODUCTION TO CALIFORNIA DENTAL NETWORK'S BENEFIT PLANS

California Dental Network offers a variety of dental benefit plans to individuals, families and groups of all sizes.

Providers are allowed to choose the plans they wish to accept in their office. We encourage, but do not require, providers to accept all California Dental Network plans.

Enclosed are the Principal Benefits & Coverage schedules for each benefit plan currently offered by California Dental Network, along with the standard exclusions and limitations that apply to these plans*. California Dental Network will notify you whenever the covered services or co-payments contained in these plans change, or whenever California Dental Network adds a new plan.

We recommend that you maintain these benefit plans in numeric order to facilitate your access to the Members' benefits in a timely manner.

*Please note that **Advantage Plan and Cosmetic Benefit Rider Polices supersede some of the Basic Plan Limitations and Exclusions. Offices that accept Members on these benefit programs agree to the modifications of the basic Limitations and Exclusions, and agree to abide with Plan policy regarding the interpretation of the Limitations and Exclusions as they apply to these Plans.** The Plan's benefit and coverage policies are described in detail in the Clinical Guidelines portion of the manual. The Plan reserves the right to make final coverage determinations on benefits and coverage for conditions not detailed in the Guidelines, therefore if there is some question of coverage the Plan should be consulted **prior** to providing treatment.

CALIFORNIA DENTAL NETWORK PROVIDER WEBSITE

Dental Offices are now able to access Plan information, including Member Eligibility, and Claim Status Inquiries online.

Go to *www.caldental.net* and click on the Provider Section.

Once there, your office can create an account that will allow you complete access to CDN Provider information. You will need your four-digit California Dental Network Provider Number and your Dental Office's nine-digit Federal Tax Identification Number to create your account.

This website allows you to access, view, download, and print such information as Claims Status and History, Fee Schedules, Dispute Resolution Process Information, Grievance Procedures, The Provider Manual, Encounter Data Forms, Specialty Referral Forms, and more.

If you have any questions, or if we may be of any assistance, please feel free to contact our Provider Relations Department toll-free at 877-4-DENTAL (433-6825).

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Principal Benefits & Coverage
Plan 460

- 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.

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)	$5.00
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	$20.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$20.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18 mos of initial placement.	$20.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$20.00
D1510	Space maintainer - fixed - unilateral	70% of UCR*
D1516	Space Maintainer, Fixed, mandibular.	70% of UCR*
D1517	Space Maintainer, Fixed, maxillary.	70% of UCR*
D1520	Space maintainer - removable - unilateral	70% of UCR*
D1526	Space Maintainer, removable, maxillary.	70% of UCR*

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1527	Space Maintainer, removable, mandibular.	70% of UCR*
D1550	Recement or rebond space maintainer	70% of UCR*
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	70% of UCR*
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$10.00
D2150	Amalgam - 2 surfaces, primary or permanent	$15.00
D2160	Amalgam - 3 surfaces, primary or permanent	$20.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$25.00
D2330	Resin-based composite - 1 surface, anterior	$25.00
D2331	Resin-based composite - 2 surfaces, anterior	$25.00
D2332	Resin-based composite - 3 surfaces, anterior	$25.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$40.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - 1 surface, posterior. Covered for Facial surfaces of Bicuspids Only, when Caries or Failing Restoration Exists.	$50.00
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	$175.00
D2520	Inlay - metallic - 2 surfaces	$175.00
D2530	Inlay - metallic - 3 or more surfaces	$175.00
D2542	Onlay - metallic - 2 surfaces	$250.00
D2543	Onlay - metallic - 3 surfaces	$250.00
D2544	Onlay - metallic - 4 or more surfaces	$250.00
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)	$145.00
D2720	Crown - resin with high noble metal	$175.00
D2721	Crown - resin with predominantly base metal	$175.00
D2722	Crown - resin with noble metal	$175.00
D2750	Crown - porcelain fused to high noble metal	$275.00
D2751	Crown - porcelain fused to predominantly base metal	$275.00
D2752	Crown - porcelain fused to noble metal	$275.00
275MLR	Crown-porcelain fused to any metal for molars	$350.00
D2780	Crown - 3/4 cast high noble metal	$250.00
D2781	Crown - 3/4 cast predominantly base metal	$250.00
D2782	Crown - 3/4 cast noble metal	$250.00
D2790	Crown - full cast high noble metal	$250.00
D2791	Crown - full cast predominantly base metal	$250.00
D2792	Crown - full cast noble metal	$250.00
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.	$12.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$10.00
D2920	Recement or rebond crown	$12.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2940	Sedative filling	$10.00
D2941	Interim therapeutic restoration-primary dentition	$10.00
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*	$0.00
D2952	Indirectly fabricated post and core in addition to crown*	$75.00
D2953	Each additional indirectly fabricated post - same tooth*	$0.00
D2954	Prefabricated post and core in addition to crown*	$70.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2990	Resin infiltration of incipient smooth surface lesions.	$20.00
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	$15.00
D3120	Pulp cap - indirect	$15.00
D3220	Therapeutic pulpotomy	$25.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$25.00
D3310	Root canal - anterior per tooth	$125.00
D3320	Root canal - premolar, per tooth	$150.00
D3330	Root canal - molar tooth, per tooth	$185.00
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	$45.00
D3346	Retreatment of previous root canal therapy - anterior	70% of UCR*
D3347	Retreatment of previous root canal therapy - premolar	70% of UCR*
D3348	Retreatment of previous root canal therapy - molar	70% of UCR*
D3410	Apicoectomy - anterior	$90.00
D3421	Apicoectomy- bicuspid (first root)	$90.00
D3425	Apicoectomy- molar (first root)	$90.00
D3426	Apicoectomy-(each additional root)	$90.00
D3427	Periradicular surgery without apicoectomy	$90.00
D3430	Retrograde filling - per root	$65.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$70.00
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	$150.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$130.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$65.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$150.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$130.00
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	$25.00
D4910	Periodontal maintenance - each additional	$25.00
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	$350.00
D5120	Complete lower denture	$350.00
D5130	Immediate upper denture	$350.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D5140	Immediate lower denture	$350.00
D5211	Upper partial denture - resin base	$300.00
D5212	Lower partial denture - resin base	$300.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$350.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$350.00
D5221	Immediate maxillary partial denture - resin base	$300.00
D5222	Immediate mandibular partial denture - resin base	$300.00
D5223	Immediate maxillary partial denture - metal framework	$350.00
D5224	Immediate maxillary partial denture - metal framework	$350.00
D5410	Adjust complete denture - upper	$25.00
D5411	Adjust complete denture - lower	$25.00
D5421	Adjust partial denture - upper	$20.00
D5422	Adjust partial denture - lower	$20.00
D5511	Repair broken complete denture base, mandibular.	$50.00
D5512	Repair broken complete denture base, maxillary.	$50.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$25.00
D5611	Repair resin denture base, mandibular.	$50.00
D5612	Repair resin denture base, maxillary.	$50.00
D5621	Repair cast partial framework, mandibular.	$50.00
D5622	Repair cast partial framework, maxillary.	$50.00
D5630	Repair or replace broken clasp	$25.00
D5640	Replace partial denture broken teeth - per tooth	$25.00
D5650	Add tooth to existing partial denture	$50.00
D5660	Add clasp to existing partial denture	$50.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$125.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$125.00
D5730	Reline complete upper denture (chairside)	$65.00
D5731	Reline complete lower denture (chairside)	$65.00
D5740	Reline upper partial denture (chairside)	$65.00
D5741	Reline lower partial denture (chairside)	$65.00
D5750	Reline complete upper denture (laboratory)	$100.00
D5751	Reline complete lower denture (laboratory)	$100.00
D5760	Reline upper partial denture (laboratory)	$100.00
D5761	Reline lower partial denture (laboratory)	$100.00
D5820	Interim partial denture (upper)	$150.00
D5821	Interim partial denture (lower)	$150.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
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	$200.00
D6211	Pontic - cast predominantly base metal	$200.00
D6212	Pontic - cast noble metal	$200.00
D6240	Pontic - porcelain fused to high noble metal	$200.00
D6241	Pontic - porcelain fused to predominantly base metal	$200.00
D6242	Pontic - porcelain fused to noble metal	$200.00
624MLR	Pontic- porcelain fused to any metal for molars	$275.00
D6250	Pontic - resin with high noble metal	$175.00
D6251	Pontic - resin with predominantly base metal	$175.00
D6252	Pontic - resin with noble metal	$175.00
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
D6602	Inlay - cast high noble metal, 2 surfaces	$175.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$175.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$175.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$175.00
D6606	Inlay - cast noble metal, 2 surfaces	$175.00
D6607	Inlay - cast noble metal, 3 or more surface	$175.00
D6610	Onlay - cast high noble metal, 2 surfaces	$250.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$250.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6612	Onlay - cast predominantly base metal, 2 surfaces	$250.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$250.00
D6614	Onlay - cast noble metal, 2 surfaces	$250.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$250.00
D6720	Crown - resin with high noble metal	$175.00
D6721	Crown - resin with predominantly base metal	$175.00
D6722	Crown - resin with noble metal	$175.00
D6750	Crown - porcelain fused to high noble metal	$275.00
D6751	Crown - porcelain fused to predominantly base metal	$275.00
D6752	Crown - porcelain fused to noble metal	$275.00
675MLR	Crown-porcelain fused to any metal for Molars	$350.00
D6780	Crown - 3/4 cast high noble metal	$200.00
D6781	Crown - 3/4 cast predominantly base metal	$200.00
D6782	Crown - 3/4 cast noble metal	$200.00
D6790	Crown - full cast high noble metal	$200.00
D6791	Crown - full cast predominantly base metal	$200.00
D6792	Crown - full cast noble metal	$200.00
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	$25.00
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	$25.00
D7140	Extraction, erupted tooth or exposed root	$25.00
D7210	Surgical removal of erupted tooth	$45.00
D7220	Removal of impacted tooth - soft tissue	$60.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	70% of UCR*
D7241	Removal of impacted tooth - completely bony, with unusual complications	70% of UCR*
D7250	Surgical removal of residual tooth roots (cutting procedure)	70% of UCR*
D7251	Coronectomy - intentional partial tooth removal	70% of UCR*
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	70% of UCR*
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	70% of UCR*
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	70% of UCR*
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	70% of UCR*
D7510	Incision and drainage of abscess - intraoral soft tissue	$40.00
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*	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$1,975.00
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$25.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	UCR*
D8681	Removable orthodontic retainer adjustment	$20.00
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.	UCR*
	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	$20.00
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

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CODE	DESCRIPTION	MEMBER COPAYMENT
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)	$8.00
D9440	Office visit - after regularly scheduled hours	$25.00
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:

460 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 dental specialist will provide Members the covered, approved, services listed above at a 30% discount from the participating contracted specialist's UCR fees. Not all types of specialists are available in all areas. Please contact the Plan.

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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

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

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- 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®).

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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- 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.

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	$5.00
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	$25.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$25.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18 mos of initial placement.	$25.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$25.00
D1510	Space maintainer - fixed - unilateral	$55.00
D1516	Space Maintainer, Fixed, mandibular.	$55.00
D1517	Space Maintainer, Fixed, maxillary.	$55.00
D1520	Space maintainer - removable - unilateral	$55.00
D1526	Space Maintainer, removable, maxillary.	$55.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1527	Space Maintainer, removable, mandibular.	$55.00
D1550	Recement or rebond space maintainer	$10.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$55.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$15.00
D2150	Amalgam - 2 surfaces, primary or permanent	$20.00
D2160	Amalgam - 3 surfaces, primary or permanent	$25.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$28.00
D2330	Resin-based composite - 1 surface, anterior	$25.00
D2331	Resin-based composite - 2 surfaces, anterior	$25.00
D2332	Resin-based composite - 3 surfaces, anterior	$25.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$28.00
D2390	Resin-based composite crown, anterior	$30.00
D2391	Resin-based composite - 1 surface, posterior. Covered for Facial surfaces of Bicuspids Only, when Caries or Failing Restoration Exists.	$30.00
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	$140.00
D2543	Onlay - metallic - 3 surfaces	$140.00
D2544	Onlay - metallic - 4 or more surfaces	$140.00
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)	$85.00
D2720	Crown - resin with high noble metal	$110.00
D2721	Crown - resin with predominantly base metal	$110.00
D2722	Crown - resin with noble metal	$110.00
D2750	Crown - porcelain fused to high noble metal	$165.00
D2751	Crown - porcelain fused to predominantly base metal	$165.00
D2752	Crown - porcelain fused to noble metal	$165.00
275MLR	Crown-porcelain fused to any metal for molars	$250.00
D2780	Crown - 3/4 cast high noble metal	$140.00
D2781	Crown - 3/4 cast predominantly base metal	$140.00
D2782	Crown - 3/4 cast noble metal	$140.00
D2790	Crown - full cast high noble metal	$145.00
D2791	Crown - full cast predominantly base metal	$145.00
D2792	Crown - full cast noble metal	$145.00
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations.	$12.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$10.00
D2920	Recement or rebond crown	$12.00
D2930	Prefabricated stainless steel crown - primary tooth	$30.00
D2931	Prefabricated stainless steel crown - permanent tooth	$45.00
D2940	Sedative filling	$7.00
D2941	Interim therapeutic restoration-primary dentition	$7.00
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*	$0.00
D2952	Indirectly fabricated post and core in addition to crown*	$65.00
D2953	Each additional indirectly fabricated post - same tooth*	$0.00
D2954	Prefabricated post and core in addition to crown*	$50.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2990	Resin infiltration of incipient smooth surface lesions.	$25.00
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	$10.00
D3120	Pulp cap - indirect	$10.00
D3220	Therapeutic pulpotomy	$20.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$15.00
D3310	Root canal - anterior per tooth	$100.00
D3320	Root canal - premolar, per tooth	$130.00
D3330	Root canal - molar tooth, per tooth	$175.00
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	$35.00
D3346	Retreatment of previous root canal therapy - anterior	70% of UCR*
D3347	Retreatment of previous root canal therapy - premolar	70% of UCR*
D3348	Retreatment of previous root canal therapy - molar	70% of UCR*
D3410	Apicoectomy - anterior	$100.00
D3421	Apicoectomy- bicuspid (first root)	$100.00
D3425	Apicoectomy- molar (first root)	$100.00
D3426	Apicoectomy-(each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$100.00
D3430	Retrograde filling - per root	$100.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$75.00
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	$115.00
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	$150.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$100.00
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	$20.00
D4910	Periodontal maintenance - each additional	$20.00
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	$250.00
D5120	Complete lower denture	$250.00
D5130	Immediate upper denture	$250.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D5140	Immediate lower denture	$250.00
D5211	Upper partial denture - resin base	$225.00
D5212	Lower partial denture - resin base	$225.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$255.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$255.00
D5221	Immediate maxillary partial denture - resin base	$225.00
D5222	Immediate mandibular partial denture - resin base	$225.00
D5223	Immediate maxillary partial denture - metal framework	$255.00
D5224	Immediate maxillary partial denture - metal framework	$255.00
D5410	Adjust complete denture - upper	$12.00
D5411	Adjust complete denture - lower	$12.00
D5421	Adjust partial denture - upper	$12.00
D5422	Adjust partial denture - lower	$12.00
D5511	Repair broken complete denture base, mandibular.	$28.00
D5512	Repair broken complete denture base, maxillary.	$28.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$22.50
D5611	Repair resin denture base, mandibular.	$28.00
D5612	Repair resin denture base, maxillary.	$28.00
D5621	Repair cast partial framework, mandibular.	$31.00
D5622	Repair cast partial framework, maxillary.	$31.00
D5630	Repair or replace broken clasp	$31.00
D5640	Replace partial denture broken teeth - per tooth	$31.00
D5650	Add tooth to existing partial denture	$31.00
D5660	Add clasp to existing partial denture	$31.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$90.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$90.00
D5730	Reline complete upper denture (chairside)	$35.00
D5731	Reline complete lower denture (chairside)	$35.00
D5740	Reline upper partial denture (chairside)	$35.00
D5741	Reline lower partial denture (chairside)	$35.00
D5750	Reline complete upper denture (laboratory)	$65.00
D5751	Reline complete lower denture (laboratory)	$65.00
D5760	Reline upper partial denture (laboratory)	$65.00
D5761	Reline lower partial denture (laboratory)	$65.00
D5820	Interim partial denture (upper)	$100.00
D5821	Interim partial denture (lower)	$100.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
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	$145.00
D6211	Pontic - cast predominantly base metal	$145.00
D6212	Pontic - cast noble metal	$145.00
D6240	Pontic - porcelain fused to high noble metal	$165.00
D6241	Pontic - porcelain fused to predominantly base metal	$165.00
D6242	Pontic - porcelain fused to noble metal	$165.00
624MLR	Pontic- porcelain fused to any metal for molars	$250.00
D6250	Pontic - resin with high noble metal	$145.00
D6251	Pontic - resin with predominantly base metal	$145.00
D6252	Pontic - resin with noble metal	$145.00
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
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	$140.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$140.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6612	Onlay - cast predominantly base metal, 2 surfaces	$140.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$140.00
D6614	Onlay - cast noble metal, 2 surfaces	$140.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$140.00
D6720	Crown - resin with high noble metal	$145.00
D6721	Crown - resin with predominantly base metal	$145.00
D6722	Crown - resin with noble metal	$145.00
D6750	Crown - porcelain fused to high noble metal	$165.00
D6751	Crown - porcelain fused to predominantly base metal	$165.00
D6752	Crown - porcelain fused to noble metal	$165.00
675MLR	Crown-porcelain fused to any metal for Molars	$250.00
D6780	Crown - 3/4 cast high noble metal	$145.00
D6781	Crown - 3/4 cast predominantly base metal	$145.00
D6782	Crown - 3/4 cast noble metal	$145.00
D6790	Crown - full cast high noble metal	$145.00
D6791	Crown - full cast predominantly base metal	$145.00
D6792	Crown - full cast noble metal	$145.00
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	$18.00
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	$19.00
D7140	Extraction, erupted tooth or exposed root	$19.00
D7210	Surgical removal of erupted tooth	$40.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$65.00
D7240	Removal of impacted tooth - completely bony	70% of UCR*
D7241	Removal of impacted tooth - completely bony, with unusual complications	70% of UCR*
D7250	Surgical removal of residual tooth roots (cutting procedure)	70% of UCR*
D7251	Coronectomy - intentional partial tooth removal	70% of UCR*
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$90.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$90.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$80.00
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	$30.00
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	$12.00
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.	UCR*
	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	$10.00
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

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CODE	DESCRIPTION	MEMBER COPAYMENT
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	$20.00
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:

411 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 dental specialist will provide Members the covered, approved, services listed above at a 30% discount from the participating contracted specialist's UCR fees. Not all types of specialists are available in all areas. Please contact the Plan.

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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

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

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- 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®).

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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- 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

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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

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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

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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

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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

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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.

California Dental Network, Inc is licensed by the California
Department of Managed Health Care under
the Knox Keene Health Care Service Plan Act (License number 933-0286).

Goes with 595 Plan upgrades.

COSMETIC BENEFITS RIDER

ADA CODE	PROCEDURE	MEMBER PAYS
Kiddie Bridge		
D6985	Pediatric Partial Denture – Fixed, Temporary	$180.00
Tooth Colored Fillings		
D2391	Resin-Based Composite – One Surface, Back Tooth	$60.00
D2392	Resin-Based Composite – Two Surfaces, Back Tooth	$80.00
D2393	Resin-Based Composite – Three Surfaces, Back Tooth	$100.00
D2394	Resin-Based Composite – Four or More Surfaces, Back Tooth	$120.00
Inlay/Onlay Restorations		
D2610	Inlay – Porcelain/Ceramic – One Surface	$240.00
D2620	Inlay – Porcelain/Ceramic – Two Surfaces	$350.00
D2630	Inlay – Porcelain/Ceramic – Three or More Surfaces	$400.00
D2642	Onlay – Porcelain/Ceramic – Two Surfaces	$425.00
D2643	Onlay – Porcelain/Ceramic – Three Surfaces	$450.00
D2644	Onlay – Porcelain/Ceramic – Four or More Surfaces	$475.00
D2650	Inlay – Resin-Based Composite – One Surface	$200.00
D2651	Inlay – Resin-Based Composite – Two Surfaces	$300.00
D2652	Inlay – Resin-Based Composite – Three or More Surfaces	$325.00
D2662	Onlay – Resin-Based Composite – Two Surfaces	$350.00
D2663	Onlay – Resin-Based Composite – Three Surfaces	$375.00
D2664	Onlay – Resin-Based Composite – Four or More Surfaces.	$400.00
Other Restorative Services		
D2910	Recement/Rebond Veneers, Ceramic Inlays/Onlays, Ceramic/Partial Coverage Restoration	$100.00
D2932	Prefabricated Resin Crown, When Placed As A Permanent Restoration	$100.00
D2960	Labial Veneer (Resin Laminate) – Chairside	$150.00
D2961	Labial Veneer (Resin Laminate) – Laboratory	$400.00
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	$400.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00
Teeth Whitening		
D9972	External bleaching - per arch, performed in office	$250.00
D9975	External bleaching for home application- per arch	$125.00
Elective/Upgrade Procedures (When Crowns or Bridges Are Not the Covered Benefit)		
D2750 - D2752	Porcelain Fused to Metal* Crown including Molars	$395.00
D2933	Prefabricated stainless steel crown with resin window	$175.00
D2934	Prefabricated esthetic coated stainless steel crown	$175.00
D6210 - D6212	Cast Metal* Pontic	$325.00
D6240 - D6242	Porcelain Fused to Metal* Pontic, False Tooth, When Performed As Upgrade to Removable Prosthesis	$350.00
D6750 - D6752	Porcelain Fused to Metal* Abutment Crown, When Performed As Upgrade To Removable Prosthesis	$395.00
D6780 - D6782	¾ Cast Metal* Abutment Crown	$350.00
D6790 - D6792	Full Cast Metal* Abutment Crown	$350.00

Coverage for all procedures is as performed by a general dentist and is subject to Plan limitations, exclusions, and guidelines.

D9940.....Night Guards, Soft, Includes Lab Fee..... $175.00

Except for bleaching, the above listed cosmetic services are treatment options that Members may elect as upgrades to other covered services that are dentally necessary at the time of treatment or when recommended by the dentist.

* Plus actual dental laboratory fees, including the cost of precious metal.

California Dental Network
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Principal Benefits & Coverage Plan
Advantage 250

- 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.

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	$0.00
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
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector.	$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
D0277	Vertical bitewings - 7 to 8 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	$0.00
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 6 MONTHS.		
D1110	Prophylaxis - adult #	$0.00
D1110	Prophylaxis - adult (each additional beyond the once per every 6 month benefit)	$45.00
D1120	Prophylaxis - child #	$0.00
D1120	Prophylaxis - child (each additional beyond the once per every 6 month benefit)	$35.00
D1206	Topical Fluoride Varnish. Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish.+	$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	$15.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$15.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18mos of initial placement.	$15.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$15.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1510	Space maintainer - fixed - unilateral	$75.00
D1516	Space Maintainer, Fixed, mandibular.	$85.00
D1517	Space Maintainer, Fixed, maxillary.	$85.00
D1520	Space maintainer - removable - unilateral	$75.00
D1526	Space Maintainer, removable, maxillary.	$85.00
D1527	Space Maintainer, removable, mandibular.	$85.00
D1550	Recement or rebond space maintainer	$10.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$75.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$20.00
D2331	Resin-based composite - 2 surfaces, anterior	$30.00
D2332	Resin-based composite - 3 surfaces, anterior	$40.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$50.00
D2390	Resin-based composite crown, anterior	$100.00
D2391	Resin-based composite - 1 surface, posterior	$80.00
D2392	Resin-based composite - 2 surfaces, posterior	$120.00
D2393	Resin-based composite - 3 surfaces, posterior	$150.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$185.00
INLAYS/ONLAYS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D2510	Inlay - metallic - 1 surface	$130.00
D2520	Inlay - metallic - 2 surfaces	$140.00
D2530	Inlay - metallic - 3 or more surfaces	$150.00
D2542	Onlay - metallic - 2 surfaces	$150.00
D2543	Onlay - metallic - 3 surfaces	$160.00
D2544	Onlay - metallic - 4 or more surfaces	$170.00
D2610	Inlay - porcelain/ceramic - 1 surface	$250.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$275.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$300.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$300.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$315.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$325.00
D2650	Inlay - resin-based composite - 1 surface	$110.00
D2651	Inlay - resin-based composite - 2 surfaces	$115.00
D2652	Inlay - resin-based composite - 3 or more surfaces	$120.00
D2662	Onlay - resin-based composite - 2 surfaces	$130.00
D2663	Onlay - resin-based composite - 3 surfaces	$135.00
D2664	Onlay - resin-based composite - 4 or more surfaces	$140.00
CROWNS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.		
D2740	Crown - porcelain/ceramic	$400.00
D2750	Crown - porcelain fused to high noble metal	$400.00
D2751	Crown - porcelain fused to predominantly base metal	$250.00
D2752	Crown - porcelain fused to noble metal	$350.00
275MLR	Crown-porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D2780	Crown - 3/4 cast high noble metal	$400.00
D2781	Crown - 3/4 cast predominantly base metal	$250.00
D2782	Crown - 3/4 cast noble metal	$350.00
D2783	Crown - 3/4 porcelain/ceramic	$400.00
D2790	Crown - full cast high noble metal	$400.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2791	Crown - full cast predominantly base metal	$250.00
D2792	Crown - full cast noble metal	$350.00
D2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium,	$400.00
279MLR	Crown-Titanium, Includes full titanium and porcelain fused to titanium, for molars.	Add $75 to nonmolar copayment fee for porcelain fused to titanium crowns.
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations. D2910 shall only be covered when recementing metallic substrate restorations.	$15.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$15.00
D2920	Recement or rebond crown	$15.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$150.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown	$100.00
D2933	Prefabricated stainless crown with resin window	$100.00
D2934	Prefabricated esthetic coated stainless steel crown--primary tooth	$1,005.00
D2940	Sedative filling	$10.00
D2941	Interim therapeutic restoration-primary dentition	$10.00
D2949	Restorative foundation for an indirect restoration	$0.00
D2950	Core buildup, including any pins when required*	$20.00
D2951	Pin retention - per tooth, in addition to restoration*	$5.00
D2952	Indirectly fabricated post and core in addition to crown	$75.00
D2953	Each additional indirectly fabricated post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown*	$70.00
D2955	Post removal (not chargeable when in conjunction with endodontic therapy)*	$35.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2990	Resin infiltration of incipient smooth surface lesions.	$15.00
LABIAL VENEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)		
D2961	Labial veneer (resin laminate) - laboratory	$400.00
D2962	Labial veneer (porcelain laminate) - laboratory	$400.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00
ALTERNATIVE CROWNS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
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	$15.00
D3120	Pulp cap - indirect	$15.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D3220	Therapeutic pulpotomy	$25.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$40.00
D3310	Root canal - anterior per tooth	$125.00
D3320	Root canal - premolar, per tooth	$150.00
D3330	Root canal - molar tooth, per tooth	$285.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70%UCR
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$150.00
D3346	Retreatment of previous root canal therapy - anterior	$250.00
D3347	Retreatment of previous root canal therapy - premolar	$300.00
D3348	Retreatment of previous root canal therapy - molar	$375.00
D3351	Apexification/recalcification - initial visit	$135.00
D3352	Apexification/recalcification - interim medication replacement	$125.00
D3353	Apexification/recalcification - final visit (includes completed root canal)	$135.00
D3355	Pulpal regeneration-initial visit	$135.00
D3356	Pulpal regeneration-interim medication replacement	$125.00
D3357	Pulpal regeneration-completion of treatment	$135.00
D3410	Apicoectomy - anterior	$275.00
D3421	Apicoectomy- bicuspid (first root)	$275.00
D3425	Apicoectomy- molar (first root)	$275.00
D3426	Apicoectomy-(each additional root)	$125.00
D3427	Periradicular surgery without apicoectomy	$275.00
D3430	Retrograde filling - per root	$150.00
D3450	Root amputation - per root	$200.00
D3920	Hemisection (including any root removal), not including root canal therapy	$150.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$75.00
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	$175.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$75.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$40.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$400.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$250.00
D4249	Clinical crown lengthening - hard tissue. D4249, when performed the same day as impression will be considered to be D4212.#	$175.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	$400.00
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	$300.00
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$350.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$225.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$65.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant #	$50.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation *, #	$0.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, each additional. #	$45.00
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)	$25.00
D4381	Localized delivery of antimicrobial agents, per tooth	$60.00
D4910	Periodontal maintenance - once every 6 months	$50.00
D4910	Periodontal maintenance - each additional	$50.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00
D4921	Gingival Irrigation (Per quadrant in conjunction with D4341/D4342. Per visit in conjunction with D1110/D1120, 4355, D4346 or D4910. See Clinical Guidelines)	$40.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
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.		
* RELINE, REPAIR, REBASE, AND REPLACE OF THERMOPLASTIC PARTIALS IS COVERED ONLY ON ADVANTAGE PLANS. ON ADVANTAGE PLANS ADD $25 TO LISTED COPAYMENT FOR REPAIRS/RELINES/REBASES OF THERMOPLASTIC/FLEXIBLE BASE FULL AND PARTIAL DENTURES.		
D5110	Complete upper denture	$350.00
D5120	Complete lower denture	$350.00
D5130	Immediate upper denture	$350.00
D5140	Immediate lower denture	$350.00
D5211	Upper partial denture - resin base	$300.00
D5212	Lower partial denture - resin base	$300.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$400.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$400.00
D5221	Immediate maxillary partial denture - resin base	$300.00
D5222	Immediate mandibular partial denture - resin base	$300.00
D5223	Immediate maxillary partial denture - metal framework	$400.00
D5224	Immediate maxillary partial denture - metal framework	$400.00
D5225	Upper partial denture - flexible base	$450.00
D5226	Lower partial denture - flexible base	$450.00
D5410	Adjust complete denture - upper	$25.00
D5411	Adjust complete denture - lower	$25.00
D5421	Adjust partial denture - upper	$20.00
D5422	Adjust partial denture - lower	$20.00
D5511	Repair broken complete denture base, mandibular. *	$50.00
D5512	Repair broken complete denture base, maxillary. *	$50.00
D5520	Replace missing or broken teeth - complete denture (each tooth)*	$25.00
D5611	Repair resin denture base, mandibular.*	$50.00
D5612	Repair resin denture base, maxillary.*	$50.00
D5621	Repair cast partial framework, mandibular.	$50.00
D5622	Repair cast partial framework, maxillary.	$50.00
D5630	Repair or replace broken clasp*	$40.00
D5640	Replace partial denture broken teeth - per tooth	$25.00
D5650	Add tooth to existing partial denture*	$50.00
D5660	Add clasp to existing partial denture*	$50.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$350.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$350.00
D5710	Rebase complete upper denture	$95.00
D5711	Rebase complete lower denture	$95.00
D5720	Rebase upper partial denture	$95.00
D5721	Rebase lower partial denture	$95.00
D5730	Reline complete upper denture (chairside)	$65.00
D5731	Reline complete lower denture (chairside)	$65.00
D5740	Reline upper partial denture (chairside)	$65.00
D5741	Reline lower partial denture (chairside)	$65.00
D5750	Reline complete upper denture (laboratory)*	$100.00
D5751	Reline complete lower denture (laboratory)*	$100.00
D5760	Reline upper partial denture (laboratory)*	$100.00
D5761	Reline lower partial denture (laboratory)*	$100.00
D5820	Interim partial denture (upper)	$150.00
D5821	Interim partial denture (lower)	$150.00
D5850	Tissue conditioning, upper	$25.00
D5851	Tissue conditioning, lower	$25.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
ALTERNATIVE DENTURES, FULL + PARTIAL, & RELINES		
MOST DENTAL OFFICES OFFER ALTERNATIVES TO STANDARD COMPLETE AND PARTIAL DENTURES AND RELINES WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	Complete Denture	
	Comfort Flex - Complete Upper Denture	$700.00
	Comfort Flex - Complete Lower Denture	$700.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
	Geneva - Complete Upper Denture	$700.00
	Geneva - Complete Lower Denture	$700.00
	Partial Denture - Resin Base	
	Simply Natural/Comfort Flex - Upper Partial	$750.00
	Simply Natural/Comfort Flex - Lower Partial	$750.00
	Geneva - Upper Partial	$750.00
	Geneva - Lower Partial	$750.00
	EstheticClasp - Upper Partial	$750.00
	EstheticClasp - Lower Partial	$750.00
	CuSil - Upper Partial	$750.00
	CuSil - Lower Partial	$750.00
	Valplast - Upper Partial	$750.00
	Valplast - Lower Partial	$750.00
	Partial Denture - Cast Metal Base with Resin Saddles	
	Comfort Flex - Upper Partial	$750.00
	Comfort Flex - Lower Partial	$750.00
	Valplast - Upper Partial	$750.00
	Valplast - Lower Partial	$750.00
	Denture Relines	
	PermaSoft - Complete Upper Denture (Laboratory)	$100.00
	PermaSoft - Complete Lower Denture (Laboratory)	$100.00
	PermaSoft - Partial Upper Denture (Laboratory)	$100.00
	PermaSoft - Partial Lower Denture (Laboratory)	$100.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D6210	Pontic - cast high noble metal	$400.00
D6211	Pontic - cast predominantly base metal	$250.00
D6212	Pontic - cast noble metal	$350.00
D6214	Pontic- titanium (includes porcelain fused to titanium)	$400.00
D6240	Pontic - porcelain fused to high noble metal	$400.00
D6241	Pontic - porcelain fused to predominantly base metal	$250.00
D6242	Pontic - porcelain fused to noble metal	$350.00
624MLR	Pontic- porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D6245	Pontic – porcelain/ceramic	$425.00
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
D6600	Inlay - porcelain/ceramic, 2 surfaces	$300.00
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	$350.00
D6602	Inlay - cast high noble metal, 2 surfaces	$400.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$450.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$300.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$350.00
D6606	Inlay - cast noble metal, 2 surfaces	$350.00
D6607	Inlay - cast noble metal, 3 or more surface	$400.00
D6608	Onlay -porcelain/ceramic, 2 surfaces	$300.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$300.00
D6610	Onlay - cast high noble metal, 2 surfaces	$400.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$450.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$300.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$350.00
D6614	Onlay - cast noble metal, 2 surfaces	$350.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$400.00
D6624	Inlay - titanium	$400.00
D6634	Onlay - titanium	$400.00
D6740	Crown-porcelain/ceramic	$400.00
D6750	Crown - porcelain fused to high noble metal	$400.00
D6751	Crown - porcelain fused to predominantly base metal	$250.00
D6752	Crown - porcelain fused to noble metal	$350.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
675MLR	Crown-porcelain fused to any metal for Molars	Add $75 to nonmolar copayment fee.
D6780	Crown - 3/4 cast high noble metal	$400.00
D6781	Crown - 3/4 cast predominantly base metal	$250.00
D6782	Crown - 3/4 cast noble metal	$350.00
D6783	Crown - 3/4 porcelain/ceramic	$400.00
D6790	Crown - full cast high noble metal	$400.00
D6791	Crown - full cast predominantly base metal	$250.00
D6792	Crown - full cast noble metal	$350.00
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
D6794	Crown - titanium (includes porcelain fused to titanium)	$400.00
D6930	Recement or rebond fixed partial denture	$25.00
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	$100.00
D6985	Pediatric partial denture--Fixed, temporary	$180.00
ALTERNATIVE BRIDGE MATERIALS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
ORAL SURGERY		
INCLUDES SUTURES AND CLOTTING AGENTS; EXTRACTIONS INCLUDE MINOR SMOOTHING OF BONE.		
D7111	Extraction, coronal remnants - primary tooth	$25.00
D7140	Extraction, erupted tooth or exposed root	$25.00
D7210	Surgical removal of erupted tooth	$45.00
D7220	Removal of impacted tooth - soft tissue	$90.00
D7230	Removal of impacted tooth - partially bony	$175.00
D7240	Removal of impacted tooth - completely bony	$200.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$210.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$90.00
D7251	Coronectomy - intentional partial tooth removal	$210.00
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	$200.00
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	$90.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$90.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$100.00
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
D8050	Interceptive orthodontic treatment of the primary dentition*	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,845.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,845.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$2,045.00
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D8680	Orthodontic retention - Per Arch	$125.00
D8681	Removable orthodontic retainer adjustment	$20.00
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)	$250.00
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit.	$75.00
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
	* - COVERED ONLY FOR THE REMOVAL OF IMPACTED WISDOM TEETH (1,16,17 & 32)	
	# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
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
D9222	Deep sedation/general anesthesia – first 15 minutes*	$134.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes*	$100.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	$15.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes*	$120.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes*	$80.00
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.	$25.00
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	$35.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9999	Office visit - during regular office hours in addition to other charges	$5.00
D9630	Other drugs and/or medicaments dispensed in the office for home use.	$40.00
D9910	Application of desensitizing medicament, per visit. (not to be used under restorations)	$15.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	$15.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$0.00
D9932	In office cleaning and inspection of removable complete upper denture. Limited to once every 6 months.	$10.00
D9933	In office cleaning and inspection of removable complete lower denture. Limited to once every 6 months.	$10.00
D9934	In office cleaning and inspection of removable partial upper denture. Limited to once every 6 months.	$10.00
D9935	In office cleaning and inspection of removable partial lower denture. Limited to once every 6 months.	$10.00
D9942	Repair/reline occlusal guard	$40.00
D9943	Occlusal guard adjustment. Coverage is limited to only soft guards that are a Plan covered benefit.	$10.00
D9944	occlusal guard – hard appliance, full arch	$250.00
D9945	occlusal guard – soft appliance, full arch	$150.00
D9946	occlusal guard – hard appliance, partial arch	$200.00
D9951	Occlusal adjustment - limited	$20.00
D9961	duplicate/copy patient's records	$25.00
D9972	External bleaching - per arch, performed in office	$250.00
D9973	External bleaching - per tooth	$30.00
D9975	External bleaching for home application- per arch	$125.00
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	$25.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

Specialty Coverage:

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A250 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "LS" after the Plan number on their identification card, or, for Advantage plans those that have NO suffix on the plan number, and they are limited to $1,000 in benefits paid by the Plan on the Member's behalf per Member 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 benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A250S 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "S" after the Plan number on their identification card, and the Member will pay the copayment amounts listed on their plan benefit schedule with no annual maximum. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A250V 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.

EXCLUSIONS AND LIMITATIONS

Some limitations and exclusions are waived for Members on Advantage Plans. See 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.

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- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- 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 to a maximum of $500 per Member per year.
- 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:

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  - 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®).

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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Principal Benefits & Coverage Plan
Advantage 200

- 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.

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	$0.00
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
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector.	$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
D0277	Vertical bitewings - 7 to 8 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	$0.00
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 6 MONTHS.		
D1110	Prophylaxis - adult #	$0.00
D1110	Prophylaxis - adult (each additional beyond the once per every 6 month benefit)	$45.00
D1120	Prophylaxis - child #	$0.00
D1120	Prophylaxis - child (each additional beyond the once per every 6 month benefit)	$35.00
D1206	Topical Fluoride Varnish. Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish. +	$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	$8.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$8.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18mos of initial placement.	$8.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$8.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1510	Space maintainer - fixed - unilateral	$55.00
D1516	Space Maintainer, Fixed, mandibular.	$65.00
D1517	Space Maintainer, Fixed, maxillary.	$65.00
D1520	Space maintainer - removable - unilateral	$55.00
D1526	Space Maintainer, removable, maxillary.	$65.00
D1527	Space Maintainer, removable, mandibular.	$65.00
D1550	Recement or rebond space maintainer	$10.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$55.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$10.00
D2331	Resin-based composite - 2 surfaces, anterior	$20.00
D2332	Resin-based composite - 3 surfaces, anterior	$25.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$30.00
D2390	Resin-based composite crown, anterior	$90.00
D2391	Resin-based composite - 1 surface, posterior.	$75.00
D2392	Resin-based composite - 2 surfaces, posterior	$110.00
D2393	Resin-based composite - 3 surfaces, posterior	$140.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$170.00
INLAYS/ONLAYS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D2510	Inlay - metallic - 1 surface	$110.00
D2520	Inlay - metallic - 2 surfaces	$120.00
D2530	Inlay - metallic - 3 or more surfaces	$130.00
D2542	Onlay - metallic - 2 surfaces	$130.00
D2543	Onlay - metallic - 3 surfaces	$140.00
D2544	Onlay - metallic - 4 or more surfaces	$150.00
D2610	Inlay - porcelain/ceramic - 1 surface	$225.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$250.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$265.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$265.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$280.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$290.00
D2650	Inlay - resin-based composite - 1 surface	$100.00
D2651	Inlay - resin-based composite - 2 surfaces	$105.00
D2652	Inlay - resin-based composite - 3 or more surfaces	$110.00
D2662	Onlay - resin-based composite - 2 surfaces	$100.00
D2663	Onlay - resin-based composite - 3 surfaces	$110.00
D2664	Onlay - resin-based composite - 4 or more surfaces	$115.00
CROWNS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.		
D2740	Crown - porcelain/ceramic	$350.00
D2750	Crown - porcelain fused to high noble metal	$350.00
D2751	Crown - porcelain fused to predominantly base metal	$200.00
D2752	Crown - porcelain fused to noble metal	$300.00
275MLR	Crown-porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D2780	Crown - 3/4 cast high noble metal	$350.00
D2781	Crown - 3/4 cast predominantly base metal	$200.00
D2782	Crown - 3/4 cast noble metal	$300.00
D2783	Crown - 3/4 porcelain/ceramic	$350.00
D2790	Crown - full cast high noble metal	$350.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2791	Crown - full cast predominantly base metal	$200.00
D2792	Crown - full cast noble metal	$300.00
D2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium,	$350.00
279MLR	Crown-Titanium, Includes full titanium and porcelain fused to titanium, for molars.	Add $75 to nonmolar copayment fee for porcelain fused to titanium crowns.
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations. D2910 shall only be covered when recementing metallic substrate restorations.	$10.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$10.00
D2920	Recement or rebond crown	$10.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$140.00
D2930	Prefabricated stainless steel crown - primary tooth	$40.00
D2931	Prefabricated stainless steel crown - permanent tooth	$40.00
D2932	Prefabricated resin crown	$90.00
D2933	Prefabricated stainless crown with resin window	$90.00
D2934	Prefabricated esthetic coated stainless steel crown--primary tooth	$95.00
D2940	Sedative filling	$10.00
D2941	Interim therapeutic restoration-primary dentition	$10.00
D2949	Restorative foundation for an indirect restoration	$0.00
D2950	Core buildup, including any pins when required*	$20.00
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
D2954	Prefabricated post and core in addition to crown*	$60.00
D2955	Post removal (not chargeable when in conjunction with endodontic therapy)*	$35.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2990	Resin infiltration of incipient smooth surface lesions.	$8.00
LABIAL V	**NEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)**	
D2961	Labial veneer (resin laminate) - laboratory	$400.00
D2962	Labial veneer (porcelain laminate) - laboratory	$400.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00

ALTERNATIVE CROWNS

MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.

	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00

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

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CODE	DESCRIPTION	MEMBER COPAYMENT
D3120	Pulp cap - indirect	$5.00
D3220	Therapeutic pulpotomy	$25.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$30.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$30.00
D3310	Root canal - anterior per tooth	$115.00
D3320	Root canal - premolar, per tooth	$130.00
D3330	Root canal - molar tooth, per tooth	$260.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70%UCR
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$125.00
D3346	Retreatment of previous root canal therapy - anterior	$225.00
D3347	Retreatment of previous root canal therapy - premolar	$275.00
D3348	Retreatment of previous root canal therapy - molar	$300.00
D3351	Apexification/recalcification - initial visit	$105.00
D3352	Apexification/recalcification - interim medication replacement	$95.00
D3353	Apexification/recalcification - final visit (includes completed root canal)	$105.00
D3355	Pulpal regeneration-initial visit	$105.00
D3356	Pulpal regeneration-interim medication replacement	$95.00
D3357	Pulpal regeneration-completion of treatment	$105.00
D3410	Apicoectomy - anterior	$250.00
D3421	Apicoectomy- bicuspid (first root)	$250.00
D3425	Apicoectomy- molar (first root)	$250.00
D3426	Apicoectomy-(each additional root)	$125.00
D3427	Periradicular surgery without apicoectomy	$250.00
D3430	Retrograde filling - per root	$150.00
D3450	Root amputation - per root	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy	$125.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$75.00
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	$125.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$70.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$35.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$350.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$250.00
D4249	Clinical crown lengthening - hard tissue. D4249, when performed the same day as impression will be considered to be D4212.#	$150.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	$350.00
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	$275.00
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$300.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$200.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant #	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation *, #	$0.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, each additional. #	$45.00
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)	$25.00
D4381	Localized delivery of antimicrobial agents, per tooth	$60.00
D4910	Periodontal maintenance - once every 6 months	$40.00
D4910	Periodontal maintenance - each additional	$50.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D4921	Gingival Irrigation (Per quadrant in conjunction with D4341/D4342. Per visit in conjunction with D1110/D1120, 4355, D4346 or D4910. See Clinical Guidelines)	$40.00
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.		
* RELINE, REPAIR, REBASE, AND REPLACE OF THERMOPLASTIC PARTIALS IS COVERED ONLY ON ADVANTAGE PLANS. ON ADVANTAGE PLANS ADD $25 TO LISTED COPAYMENT FOR REPAIRS/RELINES/REBASES OF THERMOPLASTIC/FLEXIBLE BASE FULL AND PARTIAL DENTURES		
D5110	Complete upper denture	$300.00
D5120	Complete lower denture	$300.00
D5130	Immediate upper denture	$300.00
D5140	Immediate lower denture	$300.00
D5211	Upper partial denture - resin base	$250.00
D5212	Lower partial denture - resin base	$250.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$300.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$300.00
D5221	Immediate maxillary partial denture - resin base	$250.00
D5222	Immediate mandibular partial denture - resin base	$250.00
D5223	Immediate maxillary partial denture - metal framework	$300.00
D5224	Immediate maxillary partial denture - metal framework	$300.00
D5225	Upper partial denture - flexible base	$350.00
D5226	Lower partial denture - flexible base	$350.00
D5410	Adjust complete denture - upper	$15.00
D5411	Adjust complete denture - lower	$15.00
D5421	Adjust partial denture - upper	$10.00
D5422	Adjust partial denture - lower	$10.00
D5511	Repair broken complete denture base, mandibular. *	$40.00
D5512	Repair broken complete denture base, maxillary. *	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)*	$20.00
D5611	Repair resin denture base, mandibular.*	$40.00
D5612	Repair resin denture base, maxillary.*	$40.00
D5621	Repair cast partial framework, mandibular.	$40.00
D5622	Repair cast partial framework, maxillary.	$40.00
D5630	Repair or replace broken clasp*	$35.00
D5640	Replace partial denture broken teeth - per tooth	$20.00
D5650	Add tooth to existing partial denture*	$30.00
D5660	Add clasp to existing partial denture*	$30.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$265.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$265.00
D5710	Rebase complete upper denture	$75.00
D5711	Rebase complete lower denture	$75.00
D5720	Rebase upper partial denture	$75.00
D5721	Rebase lower partial denture	$75.00
D5730	Reline complete upper denture (chairside)	$50.00
D5731	Reline complete lower denture (chairside)	$50.00
D5740	Reline upper partial denture (chairside)	$50.00
D5741	Reline lower partial denture (chairside)	$50.00
D5750	Reline complete upper denture (laboratory)*	$85.00
D5751	Reline complete lower denture (laboratory)*	$85.00
D5760	Reline upper partial denture (laboratory)*	$85.00
D5761	Reline lower partial denture (laboratory)*	$85.00
D5820	Interim partial denture (upper)	$105.00
D5821	Interim partial denture (lower)	$105.00
D5850	Tissue conditioning, upper	$25.00
D5851	Tissue conditioning, lower	$25.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
ALTERNATIVE DENTURES, FULL + PARTIAL, & RELINES		
MOST DENTAL OFFICES OFFER ALTERNATIVES TO STANDARD COMPLETE AND PARTIAL DENTURES AND RELINES WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	Complete Denture	

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CODE	DESCRIPTION	MEMBER COPAYMENT
	Comfort Flex - Complete Upper Denture	$650.00
	Comfort Flex - Complete Lower Denture	$650.00
	Geneva - Complete Upper Denture	$650.00
	Geneva - Complete Lower Denture	$650.00
	Partial Denture - Resin Base	
	Simply Natural/Comfort Flex - Upper Partial	$700.00
	Simply Natural/Comfort Flex - Lower Partial	$700.00
	Geneva - Upper Partial	$700.00
	Geneva - Lower Partial	$700.00
	EstheticClasp - Upper Partial	$700.00
	EstheticClasp - Lower Partial	$700.00
	CuSil - Upper Partial	$700.00
	CuSil - Lower Partial	$700.00
	Valplast - Upper Partial	$700.00
	Valplast - Lower Partial	$700.00
	Partial Denture - Cast Metal Base with Resin Saddles	
	Comfort Flex - Upper Partial	$700.00
	Comfort Flex - Lower Partial	$700.00
	Valplast - Upper Partial	$700.00
	Valplast - Lower Partial	$700.00
	Denture Relines	
	PermaSoft - Complete Upper Denture (Laboratory)	$100.00
	PermaSoft - Complete Lower Denture (Laboratory)	$100.00
	PermaSoft - Partial Upper Denture (Laboratory)	$100.00
	PermaSoft - Partial Lower Denture (Laboratory)	$100.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D6210	Pontic - cast high noble metal	$350.00
D6211	Pontic - cast predominantly base metal	$200.00
D6212	Pontic - cast noble metal	$300.00
D6214	Pontic- titanium (includes porcelain fused to titanium)	$350.00
D6240	Pontic - porcelain fused to high noble metal	$350.00
D6241	Pontic - porcelain fused to predominantly base metal	$200.00
D6242	Pontic - porcelain fused to noble metal	$300.00
624MLR	Pontic- porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D6245	Pontic – porcelain/ceramic	$375.00
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
D6600	Inlay - porcelain/ceramic, 2 surfaces	$265.00
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	$295.00
D6602	Inlay - cast high noble metal, 2 surfaces	$350.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$400.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$250.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$300.00
D6606	Inlay - cast noble metal, 2 surfaces	$300.00
D6607	Inlay - cast noble metal, 3 or more surface	$350.00
D6608	Onlay -porcelain/ceramic, 2 surfaces	$265.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$265.00
D6610	Onlay - cast high noble metal, 2 surfaces	$350.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$400.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$250.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$300.00
D6614	Onlay - cast noble metal, 2 surfaces	$300.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$350.00
D6624	Inlay - titanium	$350.00
D6634	Onlay - titanium	$350.00
D6740	Crown-porcelain/ceramic	$350.00
D6750	Crown - porcelain fused to high noble metal	$350.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6751	Crown - porcelain fused to predominantly base metal	$200.00
D6752	Crown - porcelain fused to noble metal	$300.00
675MLR	Crown-porcelain fused to any metal for Molars	Add $75 to nonmolar copayment fee.
D6780	Crown - 3/4 cast high noble metal	$350.00
D6781	Crown - 3/4 cast predominantly base metal	$200.00
D6782	Crown - 3/4 cast noble metal	$300.00
D6783	Crown - 3/4 porcelain/ceramic	$350.00
D6790	Crown - full cast high noble metal	$350.00
D6791	Crown - full cast predominantly base metal	$200.00
D6792	Crown - full cast noble metal	$300.00
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
D6794	Crown - titanium (includes porcelain fused to titanium)	$350.00
D6930	Recement or rebond fixed partial denture	$25.00
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	$100.00
D6985	Pediatric partial denture--Fixed, temporary	$180.00
ALTERNATIVE BRIDGE MATERIALS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
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	$35.00
D7220	Removal of impacted tooth - soft tissue	$75.00
D7230	Removal of impacted tooth - partially bony	$150.00
D7240	Removal of impacted tooth - completely bony	$175.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$180.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80.00
D7251	Coronectomy - intentional partial tooth removal	$180.00
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	$150.00
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$50.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$50.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$70.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$70.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$75.00
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
D8050	Interceptive orthodontic treatment of the primary dentition*	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,845.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,845.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$2,045.00
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	$125.00
D8681	Removable orthodontic retainer adjustment	$10.00
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)	$250.00
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit.	$75.00
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
	* - COVERED ONLY FOR THE REMOVAL OF IMPACTED WISDOM TEETH (1,16,17 & 32)	
	# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
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
D9222	Deep sedation/general anesthesia – first 15 minutes*	$134.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes*	$100.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	$15.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes*	$120.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes*	$80.00
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.	$25.00
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	$35.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9999	Office visit - during regular office hours in addition to other charges	$5.00
D9630	Other drugs and/or medicaments dispensed in the office for home use.	$40.00
D9910	Application of desensitizing medicament, per visit. (not to be used under restorations)	$15.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	$15.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$0.00
D9932	In office cleaning and inspection of removable complete upper denture. Limited to once every 6 months.	$10.00
D9933	In office cleaning and inspection of removable complete lower denture. Limited to once every 6 months.	$10.00
D9934	In office cleaning and inspection of removable partial upper denture. Limited to once every 6 months.	$10.00
D9935	In office cleaning and inspection of removable partial lower denture. Limited to once every 6 months.	$10.00
D9942	Repair/reline occlusal guard	$40.00
D9943	Occlusal guard adjustment. Coverage is limited to only soft guards that are a Plan covered benefit.	$10.00
D9944	occlusal guard – hard appliance, full arch	$250.00
D9945	occlusal guard – soft appliance, full arch	$150.00
D9946	occlusal guard – hard appliance, partial arch	$200.00
D9951	Occlusal adjustment - limited	$20.00
D9961	duplicate/copy patient's records	$25.00
D9972	External bleaching - per arch, performed in office	$250.00
D9973	External bleaching - per tooth	$30.00
D9975	External bleaching for home application- per arch	$125.00
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	$25.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

Specialty Coverage:

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A200 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "LS" after the Plan number on their identification card, or, for Advantage plans those that have NO suffix on the plan number, and they are limited to $1,000 in benefits paid by the Plan on the Member's behalf per Member 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 benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A200S 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "S" after the Plan number on their identification card, and the Member will pay the copayment amounts listed on their plan benefit schedule with no annual maximum. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A200V 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.

EXCLUSIONS AND LIMITATIONS

Some limitations and exclusions are waived for Members on Advantage Plans. See 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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- 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 to a maximum of $500 per Member per year.
- 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.

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- 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®).

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.

California Dental Network, Inc is licensed by the California
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California Dental Network
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Principal Benefits & Coverage Plan Advantage 150

- 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.

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	$0.00
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
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector.	$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
D0277	Vertical bitewings - 7 to 8 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	$0.00
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 6 MONTHS.		
D1110	Prophylaxis - adult #	$0.00
D1110	Prophylaxis - adult (each additional beyond the once per every 6 month benefit)	$45.00
D1120	Prophylaxis - child #	$0.00
D1120	Prophylaxis - child (each additional beyond the once per every 6 month benefit)	$35.00
D1206	Topical Fluoride Varnish. Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish.+	$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 18mos of initial placement.	$5.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$5.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1510	Space maintainer - fixed - unilateral	$35.00
D1516	Space Maintainer, Fixed, mandibular.	$45.00
D1517	Space Maintainer, Fixed, maxillary.	$45.00
D1520	Space maintainer - removable - unilateral	$35.00
D1526	Space Maintainer, removable, maxillary.	$55.00
D1527	Space Maintainer, removable, mandibular.	$55.00
D1550	Recement or rebond space maintainer	$0.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$35.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$10.00
D2331	Resin-based composite - 2 surfaces, anterior	$15.00
D2332	Resin-based composite - 3 surfaces, anterior	$20.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$25.00
D2390	Resin-based composite crown, anterior	$85.00
D2391	Resin-based composite - 1 surface, posterior	$70.00
D2392	Resin-based composite - 2 surfaces, posterior	$100.00
D2393	Resin-based composite - 3 surfaces, posterior	$125.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$150.00
INLAYS/ONLAYS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D2510	Inlay - metallic - 1 surface	$100.00
D2520	Inlay - metallic - 2 surfaces	$105.00
D2530	Inlay - metallic - 3 or more surfaces	$110.00
D2542	Onlay - metallic - 2 surfaces	$105.00
D2543	Onlay - metallic - 3 surfaces	$110.00
D2544	Onlay - metallic - 4 or more surfaces	$115.00
D2610	Inlay - porcelain/ceramic - 1 surface	$210.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$225.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$240.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$225.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$240.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$250.00
D2650	Inlay - resin-based composite - 1 surface	$90.00
D2651	Inlay - resin-based composite - 2 surfaces	$95.00
D2652	Inlay - resin-based composite - 3 or more surfaces	$100.00
D2662	Onlay - resin-based composite - 2 surfaces	$95.00
D2663	Onlay - resin-based composite - 3 surfaces	$100.00
D2664	Onlay - resin-based composite - 4 or more surfaces	$105.00
CROWNS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.		
D2740	Crown - porcelain/ceramic	$300.00
D2750	Crown - porcelain fused to high noble metal	$300.00
D2751	Crown - porcelain fused to predominantly base metal	$150.00
D2752	Crown - porcelain fused to noble metal	$250.00
275MLR	Crown-porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D2780	Crown - 3/4 cast high noble metal	$300.00
D2781	Crown - 3/4 cast predominantly base metal	$150.00
D2782	Crown - 3/4 cast noble metal	$250.00
D2783	Crown - 3/4 porcelain/ceramic	$300.00
D2790	Crown - full cast high noble metal	$300.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2791	Crown - full cast predominantly base metal	$150.00
D2792	Crown - full cast noble metal	$250.00
D2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium,	$300.00
279MLR	Crown-Titanium, Includes full titanium and porcelain fused to titanium, for molars.	Add $75 to nonmolar copayment fee for porcelain fused to titanium crowns.
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations. D2910 shall only be covered when recementing metallic substrate restorations.	$0.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$0.00
D2920	Recement or rebond crown	$0.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$140.00
D2930	Prefabricated stainless steel crown - primary tooth	$30.00
D2931	Prefabricated stainless steel crown - permanent tooth	$40.00
D2932	Prefabricated resin crown	$90.00
D2933	Prefabricated stainless crown with resin window	$90.00
D2934	Prefabricated esthetic coated stainless steel crown--primary tooth	$95.00
D2940	Sedative filling	$0.00
D2941	Interim therapeutic restoration-primary dentition	$0.00
D2949	Restorative foundation for an indirect restoration	$0.00
D2950	Core buildup, including any pins when required*	$20.00
D2951	Pin retention - per tooth, in addition to restoration*	$5.00
D2952	Indirectly fabricated post and core in addition to crown	$50.00
D2953	Each additional indirectly fabricated post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown*	$50.00
D2955	Post removal (not chargeable when in conjunction with endodontic therapy)*	$25.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2990	Resin infiltration of incipient smooth surface lesions.	$5.00
LABIAL VENEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)		
D2961	Labial veneer (resin laminate) - laboratory	$350.00
D2962	Labial veneer (porcelain laminate) - laboratory	$350.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00
ALTERNATIVE CROWNS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
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	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
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	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D3120	Pulp cap - indirect	$0.00
D3220	Therapeutic pulpotomy	$0.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$10.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$15.00
D3310	Root canal - anterior per tooth	$100.00
D3320	Root canal - premolar, per tooth	$110.00
D3330	Root canal - molar tooth, per tooth	$235.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70%UCR
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$100.00
D3346	Retreatment of previous root canal therapy - anterior	$120.00
D3347	Retreatment of previous root canal therapy - premolar	$145.00
D3348	Retreatment of previous root canal therapy - molar	$235.00
D3351	Apexification/recalcification - initial visit	$85.00
D3352	Apexification/recalcification - interim medication replacement	$75.00
D3353	Apexification/recalcification - final visit (includes completed root canal)	$85.00
D3355	Pulpal regeneration-initial visit	$85.00
D3356	Pulpal regeneration-interim medication replacement	$75.00
D3357	Pulpal regeneration-completion of treatment	$85.00
D3410	Apicoectomy - anterior	$225.00
D3421	Apicoectomy- bicuspid (first root)	$225.00
D3425	Apicoectomy- molar (first root)	$225.00
D3426	Apicoectomy-(each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$225.00
D3430	Retrograde filling - per root	$150.00
D3450	Root amputation - per root	$100.00
D3920	Hemisection (including any root removal), not including root canal therapy	$115.00
D3950	Canal preparation & fitting of preformed dowel or post by provider other than provider placing post.*	$75.00
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	$65.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$35.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$325.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$250.00
D4249	Clinical crown lengthening - hard tissue. D4249, when performed the same day as impression will be considered to be D4212.#	$135.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	$325.00
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	$250.00
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$250.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$175.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$35.00
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
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, each additional. #	$45.00
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)	$25.00
D4381	Localized delivery of antimicrobial agents, per tooth	$60.00
D4910	Periodontal maintenance - once every 6 months	$30.00
D4910	Periodontal maintenance - each additional	$50.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D4921	Gingival Irrigation (Per quadrant in conjunction with D4341/D4342. Per visit in conjunction with D1110/D1120, 4355, D4346 or D4910. See Clinical Guidelines)	$25.00
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.		
* RELINE, REPAIR, REBASE, AND REPLACE OF THERMOPLASTIC PARTIALS IS COVERED ONLY ON ADVANTAGE PLANS. ON ADVANTAGE PLANS ADD $25 TO LISTED COPAYMENT FOR REPAIRS/RELINES/REBASES OF THERMOPLASTIC/FLEXIBLE BASE FULL AND PARTIAL DENTURES		
D5110	Complete upper denture	$175.00
D5120	Complete lower denture	$175.00
D5130	Immediate upper denture	$175.00
D5140	Immediate lower denture	$175.00
D5211	Upper partial denture - resin base	$225.00
D5212	Lower partial denture - resin base	$225.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$225.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$225.00
D5221	Immediate maxillary partial denture - resin base	$225.00
D5222	Immediate mandibular partial denture - resin base	$225.00
D5223	Immediate maxillary partial denture - metal framework	$225.00
D5224	Immediate maxillary partial denture - metal framework	$225.00
D5225	Upper partial denture - flexible base	$225.00
D5226	Lower partial denture - flexible base	$225.00
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)*	$15.00
D5611	Repair resin denture base, mandibular.*	$15.00
D5612	Repair resin denture base, maxillary.*	$15.00
D5621	Repair cast partial framework, mandibular.	$15.00
D5622	Repair cast partial framework, maxillary.	$15.00
D5630	Repair or replace broken clasp*	$15.00
D5640	Replace partial denture broken teeth - per tooth	$15.00
D5650	Add tooth to existing partial denture*	$15.00
D5660	Add clasp to existing partial denture*	$15.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$165.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$165.00
D5710	Rebase complete upper denture	$50.00
D5711	Rebase complete lower denture	$50.00
D5720	Rebase upper partial denture	$50.00
D5721	Rebase lower partial denture	$50.00
D5730	Reline complete upper denture (chairside)	$40.00
D5731	Reline complete lower denture (chairside)	$40.00
D5740	Reline upper partial denture (chairside)	$40.00
D5741	Reline lower partial denture (chairside)	$40.00
D5750	Reline complete upper denture (laboratory)*	$40.00
D5751	Reline complete lower denture (laboratory)*	$40.00
D5760	Reline upper partial denture (laboratory)*	$40.00
D5761	Reline lower partial denture (laboratory)*	$40.00
D5820	Interim partial denture (upper)	$40.00
D5821	Interim partial denture (lower)	$40.00
D5850	Tissue conditioning, upper	$10.00
D5851	Tissue conditioning, lower	$10.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
ALTERNATIVE DENTURES, FULL + PARTIAL, & RELINES		
MOST DENTAL OFFICES OFFER ALTERNATIVES TO STANDARD COMPLETE AND PARTIAL DENTURES AND RELINES WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	Complete Denture	

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CODE	DESCRIPTION	MEMBER COPAYMENT
	Comfort Flex - Complete Upper Denture	$600.00
	Comfort Flex - Complete Lower Denture	$600.00
	Geneva - Complete Upper Denture	$600.00
	Geneva - Complete Lower Denture	$600.00
	Partial Denture - Resin Base	
	Simply Natural/Comfort Flex - Upper Partial	$650.00
	Simply Natural/Comfort Flex - Lower Partial	$650.00
	Geneva - Upper Partial	$650.00
	Geneva - Lower Partial	$650.00
	EstheticClasp - Upper Partial	$650.00
	EstheticClasp - Lower Partial	$650.00
	CuSil - Upper Partial	$650.00
	CuSil - Lower Partial	$650.00
	Valplast - Upper Partial	$650.00
	Valplast - Lower Partial	$650.00
	Partial Denture - Cast Metal Base with Resin Saddles	
	Comfort Flex - Upper Partial	$650.00
	Comfort Flex - Lower Partial	$650.00
	Valplast - Upper Partial	$650.00
	Valplast - Lower Partial	$650.00
	Denture Relines	
	PermaSoft - Complete Upper Denture (Laboratory)	$100.00
	PermaSoft - Complete Lower Denture (Laboratory)	$100.00
	PermaSoft - Partial Upper Denture (Laboratory)	$100.00
	PermaSoft - Partial Lower Denture (Laboratory)	$100.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D6210	Pontic - cast high noble metal	$300.00
D6211	Pontic - cast predominantly base metal	$150.00
D6212	Pontic - cast noble metal	$250.00
D6214	Pontic- titanium (includes porcelain fused to titanium)	$300.00
D6240	Pontic - porcelain fused to high noble metal	$300.00
D6241	Pontic - porcelain fused to predominantly base metal	$150.00
D6242	Pontic - porcelain fused to noble metal	$250.00
624MLR	Pontic- porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D6245	Pontic – porcelain/ceramic	$325.00
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
D6600	Inlay - porcelain/ceramic, 2 surfaces	$225.00
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	$240.00
D6602	Inlay - cast high noble metal, 2 surfaces	$300.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$350.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$200.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$250.00
D6606	Inlay - cast noble metal, 2 surfaces	$250.00
D6607	Inlay - cast noble metal, 3 or more surface	$300.00
D6608	Onlay -porcelain/ceramic, 2 surfaces	$225.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$240.00
D6610	Onlay - cast high noble metal, 2 surfaces	$300.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$350.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$200.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$250.00
D6614	Onlay - cast noble metal, 2 surfaces	$250.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$300.00
D6624	Inlay - titanium	$300.00
D6634	Onlay - titanium	$300.00
D6740	Crown-porcelain/ceramic	$300.00
D6750	Crown - porcelain fused to high noble metal	$300.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6751	Crown - porcelain fused to predominantly base metal	$150.00
D6752	Crown - porcelain fused to noble metal	$250.00
675MLR	Crown-porcelain fused to any metal for Molars	Add $75 to nonmolar copayment fee.
D6780	Crown - 3/4 cast high noble metal	$300.00
D6781	Crown - 3/4 cast predominantly base metal	$150.00
D6782	Crown - 3/4 cast noble metal	$250.00
D6783	Crown - 3/4 porcelain/ceramic	$300.00
D6790	Crown - full cast high noble metal	$300.00
D6791	Crown - full cast predominantly base metal	$150.00
D6792	Crown - full cast noble metal	$250.00
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
D6794	Crown - titanium (includes porcelain fused to titanium)	$300.00
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	$75.00
D6985	Pediatric partial denture--Fixed, temporary	$180.00
ALTERNATIVE BRIDGE MATERIALS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
ORAL SURGERY		
INCLUDES SUTURES AND CLOTTING AGENTS; EXTRACTIONS INCLUDE MINOR SMOOTHING OF BONE.		
D7111	Extraction, coronal remnants - primary tooth	$0.00
D7140	Extraction, erupted tooth or exposed root	$0.00
D7210	Surgical removal of erupted tooth	$30.00
D7220	Removal of impacted tooth - soft tissue	$60.00
D7230	Removal of impacted tooth - partially bony	$125.00
D7240	Removal of impacted tooth - completely bony	$150.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$155.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$60.00
D7251	Coronectomy - intentional partial tooth removal	$155.00
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	$130.00
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$10.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$10.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$10.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$10.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$60.00
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
D8050	Interceptive orthodontic treatment of the primary dentition*	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$1,975.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	$125.00
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)	$250.00
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit.	$75.00
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
	* - COVERED ONLY FOR THE REMOVAL OF IMPACTED WISDOM TEETH (1,16,17 & 32)	
	# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
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
D9222	Deep sedation/general anesthesia – first 15 minutes*	$134.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes*	$100.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	$15.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes*	$120.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes*	$80.00
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.	$25.00
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	$35.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9999	Office visit - during regular office hours in addition to other charges	$0.00
D9630	Other drugs and/or medicaments dispensed in the office for home use.	$25.00
D9910	Application of desensitizing medicament, per visit. (not to be used under restorations)	$15.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	$15.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$0.00
D9932	In office cleaning and inspection of removable complete upper denture. Limited to once every 6 months.	$10.00
D9933	In office cleaning and inspection of removable complete lower denture. Limited to once every 6 months.	$10.00
D9934	In office cleaning and inspection of removable partial upper denture. Limited to once every 6 months.	$10.00
D9935	In office cleaning and inspection of removable partial lower denture. Limited to once every 6 months.	$10.00
D9942	Repair/reline occlusal guard	$40.00
D9943	Occlusal guard adjustment. Coverage is limited to only soft guards that are a Plan covered benefit.	$10.00
D9944	occlusal guard – hard appliance, full arch	$250.00
D9945	occlusal guard – soft appliance, full arch	$150.00
D9946	occlusal guard – hard appliance, partial arch	$200.00
D9951	Occlusal adjustment - limited	$15.00
D9961	duplicate/copy patient's records	$25.00
D9972	External bleaching - per arch, performed in office	$250.00
D9973	External bleaching - per tooth	$30.00
D9975	External bleaching for home application- per arch	$125.00
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	$25.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

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Specialty Coverage:

A150 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "LS" after the Plan number on their identification card, or, for Advantage plans those that have NO suffix on the plan number, and they are limited to $1,000 in benefits paid by the Plan on the Member's behalf per Member 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 benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A150S 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "S" after the Plan number on their identification card, and the Member will pay the copayment amounts listed on their plan benefit schedule with no annual maximum. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A150V 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.

EXCLUSIONS AND LIMITATIONS

Some limitations and exclusions are waived for Members on Advantage Plans. See 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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- 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 to a maximum of $500 per Member per year.
- 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.

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- 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®).

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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Principal Benefits & Coverage Plan
Advantage 100

- 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.

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	$0.00
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
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector.	$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
D0277	Vertical bitewings - 7 to 8 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	$0.00
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 6 MONTHS.		
D1110	Prophylaxis - adult #	$0.00
D1110	Prophylaxis - adult (each additional beyond the once per every 6 month benefit)	$45.00
D1120	Prophylaxis - child #	$0.00
D1120	Prophylaxis - child (each additional beyond the once per every 6 month benefit)	$35.00
D1206	Topical Fluoride Varnish. Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish.+	$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	$0.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$0.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18mos of initial placement.	$0.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1510	Space maintainer - fixed - unilateral	$35.00
D1516	Space Maintainer, Fixed, mandibular.	$45.00
D1517	Space Maintainer, Fixed, maxillary.	$45.00
D1520	Space maintainer - removable - unilateral	$35.00
D1526	Space Maintainer, removable, maxillary.	$55.00
D1527	Space Maintainer, removable, mandibular.	$55.00
D1550	Recement or rebond space maintainer	$0.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$35.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$10.00
D2331	Resin-based composite - 2 surfaces, anterior	$12.00
D2332	Resin-based composite - 3 surfaces, anterior	$14.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$20.00
D2390	Resin-based composite crown, anterior	$75.00
D2391	Resin-based composite - 1 surface, posterior	$65.00
D2392	Resin-based composite - 2 surfaces, posterior	$85.00
D2393	Resin-based composite - 3 surfaces, posterior	$100.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$120.00
INLAYS/ONLAYS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D2510	Inlay - metallic - 1 surface	$85.00
D2520	Inlay - metallic - 2 surfaces	$90.00
D2530	Inlay - metallic - 3 or more surfaces	$95.00
D2542	Onlay - metallic - 2 surfaces	$90.00
D2543	Onlay - metallic - 3 surfaces	$95.00
D2544	Onlay - metallic - 4 or more surfaces	$100.00
D2610	Inlay - porcelain/ceramic - 1 surface	$185.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$200.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$215.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$200.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$215.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$225.00
D2650	Inlay - resin-based composite - 1 surface	$75.00
D2651	Inlay - resin-based composite - 2 surfaces	$80.00
D2652	Inlay - resin-based composite - 3 or more surfaces	$85.00
D2662	Onlay - resin-based composite - 2 surfaces	$80.00
D2663	Onlay - resin-based composite - 3 surfaces	$85.00
D2664	Onlay - resin-based composite - 4 or more surfaces	$90.00
CROWNS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.		
D2740	Crown - porcelain/ceramic	$250.00
D2750	Crown - porcelain fused to high noble metal	$250.00
D2751	Crown - porcelain fused to predominantly base metal	$100.00
D2752	Crown - porcelain fused to noble metal	$200.00
275MLR	Crown-porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D2780	Crown - 3/4 cast high noble metal	$250.00
D2781	Crown - 3/4 cast predominantly base metal	$100.00
D2782	Crown - 3/4 cast noble metal	$200.00
D2783	Crown - 3/4 porcelain/ceramic	$250.00
D2790	Crown - full cast high noble metal	$250.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2791	Crown - full cast predominantly base metal	$100.00
D2792	Crown - full cast noble metal	$200.00
D2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium,	$250.00
279MLR	Crown-Titanium, Includes full titanium and porcelain fused to titanium, for molars.	Add $75 to nonmolar copayment fee for porcelain fused to titanium crowns.
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations. D2910 shall only be covered when recementing metallic substrate restorations.	$0.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$0.00
D2920	Recement or rebond crown	$0.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$135.00
D2930	Prefabricated stainless steel crown - primary tooth	$25.00
D2931	Prefabricated stainless steel crown - permanent tooth	$35.00
D2932	Prefabricated resin crown	$85.00
D2933	Prefabricated stainless crown with resin window	$85.00
D2934	Prefabricated esthetic coated stainless steel crown--primary tooth	$90.00
D2940	Sedative filling	$0.00
D2941	Interim therapeutic restoration-primary dentition	$0.00
D2949	Restorative foundation for an indirect restoration	$0.00
D2950	Core buildup, including any pins when required*	$10.00
D2951	Pin retention - per tooth, in addition to restoration*	$5.00
D2952	Indirectly fabricated post and core in addition to crown	$50.00
D2953	Each additional indirectly fabricated post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown*	$50.00
D2955	Post removal (not chargeable when in conjunction with endodontic therapy)*	$15.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2990	Resin infiltration of incipient smooth surface lesions.	$0.00
LABIAL VENEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)		
D2961	Labial veneer (resin laminate) - laboratory	$300.00
D2962	Labial veneer (porcelain laminate) - laboratory	$300.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00
ALTERNATIVE CROWNS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
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	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D3120	Pulp cap - indirect	$0.00
D3220	Therapeutic pulpotomy	$0.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$15.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$10.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$15.00
D3310	Root canal - anterior per tooth	$75.00
D3320	Root canal - premolar, per tooth	$85.00
D3330	Root canal - molar tooth, per tooth	$200.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70%UCR
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$75.00
D3346	Retreatment of previous root canal therapy - anterior	$95.00
D3347	Retreatment of previous root canal therapy - premolar	$120.00
D3348	Retreatment of previous root canal therapy - molar	$210.00
D3351	Apexification/recalcification - initial visit	$75.00
D3352	Apexification/recalcification - interim medication replacement	$65.00
D3353	Apexification/recalcification - final visit (includes completed root canal)	$75.00
D3355	Pulpal regeneration-initial visit	$75.00
D3356	Pulpal regeneration-interim medication replacement	$65.00
D3357	Pulpal regeneration-completion of treatment	$75.00
D3410	Apicoectomy - anterior	$200.00
D3421	Apicoectomy- bicuspid (first root)	$200.00
D3425	Apicoectomy- molar (first root)	$200.00
D3426	Apicoectomy-(each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$200.00
D3430	Retrograde filling - per root	$150.00
D3450	Root amputation - per root	$100.00
D3920	Hemisection (including any root removal), not including root canal therapy	$115.00
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	$50.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$40.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$20.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$300.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$225.00
D4249	Clinical crown lengthening - hard tissue. D4249, when performed the same day as impression will be considered to be D4212.#	$125.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	$300.00
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	$225.00
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$225.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$150.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$25.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant #	$20.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation *, #	$0.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, each additional. #	$45.00
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)	$25.00
D4381	Localized delivery of antimicrobial agents, per tooth	$60.00
D4910	Periodontal maintenance - once every 6 months	$25.00
D4910	Periodontal maintenance - each additional	$50.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D4921	Gingival Irrigation (Per quadrant in conjunction with D4341/D4342. Per visit in conjunction with D1110/D1120, 4355, D4346 or D4910. See Clinical Guidelines)	$20.00
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.		
* RELINE, REPAIR, REBASE, AND REPLACE OF THERMOPLASTIC PARTIALS IS COVERED ONLY ON ADVANTAGE PLANS. ON ADVANTAGE PLANS ADD $25 TO LISTED COPAYMENT FOR REPAIRS/RELINES/REBASES OF THERMOPLASTIC/FLEXIBLE BASE FULL AND PARTIAL DENTURES		
D5110	Complete upper denture	$125.00
D5120	Complete lower denture	$125.00
D5130	Immediate upper denture	$125.00
D5140	Immediate lower denture	$125.00
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	$150.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$150.00
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	$150.00
D5224	Immediate maxillary partial denture - metal framework	$150.00
D5225	Upper partial denture - flexible base	$150.00
D5226	Lower partial denture - flexible base	$150.00
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)*	$15.00
D5611	Repair resin denture base, mandibular.*	$15.00
D5612	Repair resin denture base, maxillary.*	$15.00
D5621	Repair cast partial framework, mandibular.	$15.00
D5622	Repair cast partial framework, maxillary.	$15.00
D5630	Repair or replace broken clasp*	$15.00
D5640	Replace partial denture broken teeth - per tooth	$15.00
D5650	Add tooth to existing partial denture*	$15.00
D5660	Add clasp to existing partial denture*	$15.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$100.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$100.00
D5710	Rebase complete upper denture	$50.00
D5711	Rebase complete lower denture	$50.00
D5720	Rebase upper partial denture	$50.00
D5721	Rebase lower partial denture	$50.00
D5730	Reline complete upper denture (chairside)	$40.00
D5731	Reline complete lower denture (chairside)	$40.00
D5740	Reline upper partial denture (chairside)	$40.00
D5741	Reline lower partial denture (chairside)	$40.00
D5750	Reline complete upper denture (laboratory)*	$40.00
D5751	Reline complete lower denture (laboratory)*	$40.00
D5760	Reline upper partial denture (laboratory)*	$40.00
D5761	Reline lower partial denture (laboratory)*	$40.00
D5820	Interim partial denture (upper)	$40.00
D5821	Interim partial denture (lower)	$40.00
D5850	Tissue conditioning, upper	$10.00
D5851	Tissue conditioning, lower	$10.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
ALTERNATIVE DENTURES, FULL + PARTIAL, & RELINES		
MOST DENTAL OFFICES OFFER ALTERNATIVES TO STANDARD COMPLETE AND PARTIAL DENTURES AND RELINES WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	Complete Denture	

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CODE	DESCRIPTION	MEMBER COPAYMENT
	Comfort Flex - Complete Upper Denture	$550.00
	Comfort Flex - Complete Lower Denture	$550.00
	Geneva - Complete Upper Denture	$550.00
	Geneva - Complete Lower Denture	$550.00
	Partial Denture - Resin Base	
	Simply Natural/Comfort Flex - Upper Partial	$600.00
	Simply Natural/Comfort Flex - Lower Partial	$600.00
	Geneva - Upper Partial	$600.00
	Geneva - Lower Partial	$600.00
	EstheticClasp - Upper Partial	$600.00
	EstheticClasp - Lower Partial	$600.00
	CuSil - Upper Partial	$600.00
	CuSil - Lower Partial	$600.00
	Valplast - Upper Partial	$600.00
	Valplast - Lower Partial	$600.00
	Partial Denture - Cast Metal Base with Resin Saddles	
	Comfort Flex - Upper Partial	$600.00
	Comfort Flex - Lower Partial	$600.00
	Valplast - Upper Partial	$600.00
	Valplast - Lower Partial	$600.00
	Denture Relines	
	PermaSoft - Complete Upper Denture (Laboratory)	$100.00
	PermaSoft - Complete Lower Denture (Laboratory)	$100.00
	PermaSoft - Partial Upper Denture (Laboratory)	$100.00
	PermaSoft - Partial Lower Denture (Laboratory)	$100.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D6210	Pontic - cast high noble metal	$250.00
D6211	Pontic - cast predominantly base metal	$100.00
D6212	Pontic - cast noble metal	$200.00
D6214	Pontic- titanium (includes porcelain fused to titanium)	$250.00
D6240	Pontic - porcelain fused to high noble metal	$250.00
D6241	Pontic - porcelain fused to predominantly base metal	$100.00
D6242	Pontic - porcelain fused to noble metal	$200.00
624MLR	Pontic- porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D6245	Pontic – porcelain/ceramic	$250.00
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
D6600	Inlay - porcelain/ceramic, 2 surfaces	$200.00
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	$215.00
D6602	Inlay - cast high noble metal, 2 surfaces	$250.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$300.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$150.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$200.00
D6606	Inlay - cast noble metal, 2 surfaces	$200.00
D6607	Inlay - cast noble metal, 3 or more surface	$250.00
D6608	Onlay -porcelain/ceramic, 2 surfaces	$200.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$215.00
D6610	Onlay - cast high noble metal, 2 surfaces	$250.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$300.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$150.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$200.00
D6614	Onlay - cast noble metal, 2 surfaces	$200.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$250.00
D6624	Inlay - titanium	$250.00
D6634	Onlay - titanium	$250.00
D6740	Crown-porcelain/ceramic	$250.00
D6750	Crown - porcelain fused to high noble metal	$250.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6751	Crown - porcelain fused to predominantly base metal	$100.00
D6752	Crown - porcelain fused to noble metal	$200.00
675MLR	Crown-porcelain fused to any metal for Molars	Add $75 to nonmolar copayment fee.
D6780	Crown - 3/4 cast high noble metal	$250.00
D6781	Crown - 3/4 cast predominantly base metal	$100.00
D6782	Crown - 3/4 cast noble metal	$200.00
D6783	Crown - 3/4 porcelain/ceramic	$250.00
D6790	Crown - full cast high noble metal	$250.00
D6791	Crown - full cast predominantly base metal	$100.00
D6792	Crown - full cast noble metal	$200.00
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
D6794	Crown - titanium (includes porcelain fused to titanium)	$250.00
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
D6985	Pediatric partial denture--Fixed, temporary	$180.00
ALTERNATIVE BRIDGE MATERIALS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
ORAL SURGERY		
INCLUDES SUTURES AND CLOTTING AGENTS; EXTRACTIONS INCLUDE MINOR SMOOTHING OF BONE.		
D7111	Extraction, coronal remnants - primary tooth	$0.00
D7140	Extraction, erupted tooth or exposed root	$0.00
D7210	Surgical removal of erupted tooth	$20.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$100.00
D7240	Removal of impacted tooth - completely bony	$125.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$130.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50.00
D7251	Coronectomy - intentional partial tooth removal	$130.00
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	$110.00
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$0.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$0.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$0.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$0.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$40.00
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
D8050	Interceptive orthodontic treatment of the primary dentition*	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$1,975.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	$125.00
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)	$250.00
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit.	$75.00
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
	* - COVERED ONLY FOR THE REMOVAL OF IMPACTED WISDOM TEETH (1,16,17 & 32)	
	# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
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
D9222	Deep sedation/general anesthesia – first 15 minutes*	$117.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes*	$85.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	$15.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes*	$100.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes*	$65.00
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.	$25.00
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	$30.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9999	Office visit - during regular office hours in addition to other charges	$0.00
D9630	Other drugs and/or medicaments dispensed in the office for home use.	$20.00
D9910	Application of desensitizing medicament, per visit. (not to be used under restorations)	$15.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	$15.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$0.00
D9932	In office cleaning and inspection of removable complete upper denture. Limited to once every 6 months.	$10.00
D9933	In office cleaning and inspection of removable complete lower denture. Limited to once every 6 months.	$10.00
D9934	In office cleaning and inspection of removable partial upper denture. Limited to once every 6 months.	$10.00
D9935	In office cleaning and inspection of removable partial lower denture. Limited to once every 6 months.	$10.00
D9942	Repair/reline occlusal guard	$40.00
D9943	Occlusal guard adjustment. Coverage is limited to only soft guards that are a Plan covered benefit.	$10.00
D9944	occlusal guard – hard appliance, full arch	$250.00
D9945	occlusal guard – soft appliance, full arch	$150.00
D9946	occlusal guard – hard appliance, partial arch	$200.00
D9951	Occlusal adjustment - limited	$15.00
D9961	duplicate/copy patient's records	$25.00
D9972	External bleaching - per arch, performed in office	$250.00
D9973	External bleaching - per tooth	$25.00
D9975	External bleaching for home application- per arch	$125.00
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	$25.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

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Specialty Coverage:

A100 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "LS" after the Plan number on their identification card, or, for Advantage plans those that have NO suffix on the plan number, and they are limited to $1,000 in benefits paid by the Plan on the Member's behalf per Member 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 benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A100S 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "S" after the Plan number on their identification card, and the Member will pay the copayment amounts listed on their plan benefit schedule with no annual maximum. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A100V 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.

EXCLUSIONS AND LIMITATIONS

Some limitations and exclusions are waived for Members on Advantage Plans. See 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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- 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 to a maximum of $500 per Member per year.
- 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.

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- 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®).

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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Principal Benefits & Coverage Plan
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- 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.

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	$0.00
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
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector.	$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
D0277	Vertical bitewings - 7 to 8 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	$0.00
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 6 MONTHS.		
D1110	Prophylaxis - adult #	$0.00
D1110	Prophylaxis - adult (each additional beyond the once per every 6 month benefit)	$45.00
D1120	Prophylaxis - child #	$0.00
D1120	Prophylaxis - child (each additional beyond the once per every 6 month benefit)	$35.00
D1206	Topical Fluoride Varnish. Chargeable on a per visit basis, not per tooth.+	$5.00
D1208	Topical application of fluoride - excluding varnish.+	$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	$0.00
D1352	Preventive resin restoration - permanent tooth - including placement of a sealant in non-carious pits and fissures	$0.00
D1353	Sealant repair-per tooth. May not be charged by placing provider within 18mos of initial placement.	$0.00
D1354	Interim Caries arresting medicament application-per tooth. Does not include dental fluoride varnish application.	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D1510	Space maintainer - fixed - unilateral	$35.00
D1516	Space Maintainer, Fixed, mandibular.	$45.00
D1517	Space Maintainer, Fixed, maxillary.	$45.00
D1520	Space maintainer - removable - unilateral	$35.00
D1526	Space Maintainer, removable, maxillary.	$55.00
D1527	Space Maintainer, removable, mandibular.	$55.00
D1550	Recement or rebond space maintainer	$0.00
D1555	Removal of fixed space maintainer	$15.00
D1575	Distal shoe space maintainer - fixed - unilateral	$35.00
RESTORATIVE SERVICES		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS.		
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$0.00
D2331	Resin-based composite - 2 surfaces, anterior	$0.00
D2332	Resin-based composite - 3 surfaces, anterior	$0.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - 1 surface, posterior	$65.00
D2392	Resin-based composite - 2 surfaces, posterior	$85.00
D2393	Resin-based composite - 3 surfaces, posterior	$100.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$120.00
INLAYS/ONLAYS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D2510	Inlay - metallic - 1 surface	$80.00
D2520	Inlay - metallic - 2 surfaces	$85.00
D2530	Inlay - metallic - 3 or more surfaces	$90.00
D2542	Onlay - metallic - 2 surfaces	$85.00
D2543	Onlay - metallic - 3 surfaces	$90.00
D2544	Onlay - metallic - 4 or more surfaces	$95.00
D2610	Inlay - porcelain/ceramic - 1 surface	$175.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$195.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$210.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$195.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$205.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$210.00
D2650	Inlay - resin-based composite - 1 surface	$70.00
D2651	Inlay - resin-based composite - 2 surfaces	$75.00
D2652	Inlay - resin-based composite - 3 or more surfaces	$80.00
D2662	Onlay - resin-based composite - 2 surfaces	$75.00
D2663	Onlay - resin-based composite - 3 surfaces	$80.00
D2664	Onlay - resin-based composite - 4 or more surfaces	$85.00
CROWNS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
*COVERED ONLY AT THE GENERAL DENTIST'S OFFICE UNLESS SPECIFIC PRIOR AUTHORIZATION GIVEN BY PLAN FOR SPECIALIST TO PERFORM.		
D2740	Crown - porcelain/ceramic	$225.00
D2750	Crown - porcelain fused to high noble metal	$225.00
D2751	Crown - porcelain fused to predominantly base metal	$75.00
D2752	Crown - porcelain fused to noble metal	$175.00
275MLR	Crown-porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D2780	Crown - 3/4 cast high noble metal	$225.00
D2781	Crown - 3/4 cast predominantly base metal	$75.00
D2782	Crown - 3/4 cast noble metal	$175.00
D2783	Crown - 3/4 porcelain/ceramic	$225.00
D2790	Crown - full cast high noble metal	$225.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D2791	Crown - full cast predominantly base metal	$75.00
D2792	Crown - full cast noble metal	$175.00
D2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium,	$225.00
279MLR	Crown-Titanium, Includes full titanium and porcelain fused to titanium, for molars.	Add $75 to nonmolar copayment fee for porcelain fused to titanium crowns.
D2799	Provisional crown—further treatment or completion of diagnosis necessary prior to final impression.	$0.00
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations. D2910 shall only be covered when recementing metallic substrate restorations.	$0.00
D2915	Recement or rebond cast indirectly fabricated or prefabricated post and core	$0.00
D2920	Recement or rebond crown	$0.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$100.00
D2930	Prefabricated stainless steel crown - primary tooth	$0.00
D2931	Prefabricated stainless steel crown - permanent tooth	$0.00
D2932	Prefabricated resin crown	$50.00
D2933	Prefabricated stainless crown with resin window	$50.00
D2934	Prefabricated esthetic coated stainless steel crown--primary tooth	$55.00
D2940	Sedative filling	$0.00
D2941	Interim therapeutic restoration-primary dentition	$0.00
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*	$0.00
D2952	Indirectly fabricated post and core in addition to crown	$50.00
D2953	Each additional indirectly fabricated post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown*	$30.00
D2955	Post removal (not chargeable when in conjunction with endodontic therapy)*	$15.00
D2957	Each additional prefabricated post - same tooth*	$0.00
D2980	Crown repair, by report	$50.00
D2981	Inlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$25.00
D2982	Onlay repair due to restorative material failure- not allowed to be charged by same provider within 24 months of the original restoration.	$35.00
D2990	Resin infiltration of incipient smooth surface lesions.	$0.00
LABIAL VENEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)		
D2961	Labial veneer (resin laminate) - laboratory	$250.00
D2962	Labial veneer (porcelain laminate) - laboratory	$250.00
D2983	Veneer repair due to restorative material failure- - not allowed to be charged by same provider within 24 months of the original restoration	$50.00
ALTERNATIVE CROWNS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
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	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D3120	Pulp cap - indirect	$0.00
D3220	Therapeutic pulpotomy	$0.00
D3221	Pulpal debridement - primary and permanent when endodontic treatment not completed on same day	$15.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	$10.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	$15.00
D3310	Root canal - anterior per tooth	$50.00
D3320	Root canal - premolar, per tooth	$70.00
D3330	Root canal - molar tooth, per tooth	$150.00
D3331	Treatment of root canal obstruction - *subject to proper documentation of condition and procedure. See clinical guidelines.*	70%UCR
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$50.00
D3346	Retreatment of previous root canal therapy - anterior	$70.00
D3347	Retreatment of previous root canal therapy - premolar	$100.00
D3348	Retreatment of previous root canal therapy - molar	$190.00
D3351	Apexification/recalcification - initial visit	$55.00
D3352	Apexification/recalcification - interim medication replacement	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal)	$55.00
D3355	Pulpal regeneration-initial visit	$55.00
D3356	Pulpal regeneration-interim medication replacement	$45.00
D3357	Pulpal regeneration-completion of treatment	$55.00
D3410	Apicoectomy - anterior	$150.00
D3421	Apicoectomy- bicuspid (first root)	$150.00
D3425	Apicoectomy- molar (first root)	$200.00
D3426	Apicoectomy-(each additional root)	$100.00
D3427	Periradicular surgery without apicoectomy	$150.00
D3430	Retrograde filling - per root	$100.00
D3450	Root amputation - per root	$75.00
D3920	Hemisection (including any root removal), not including root canal therapy	$100.00
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	$40.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	$35.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth +	$20.00
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	$275.00
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	$195.00
D4249	Clinical crown lengthening - hard tissue. D4249, when performed the same day as impression will be considered to be D4212.#	$100.00
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	$250.00
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	$200.00
D4263	Bone replacement graft - first site in quadrant, Not to be used for extraction site bone grafts	$200.00
D4264	Bone replacement graft – each additional site in quadrant, Not to be used for extraction site bone grafts	$125.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant #	$20.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant #	$20.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation *, #	$0.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, each additional. #	$45.00
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)	$20.00
D4381	Localized delivery of antimicrobial agents, per tooth	$60.00
D4910	Periodontal maintenance - once every 6 months	$25.00
D4910	Periodontal maintenance - each additional	$50.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D4921	Gingival Irrigation (Per quadrant in conjunction with D4341/D4342. Per visit in conjunction with D1110/D1120, 4355, D4346 or D4910. See Clinical Guidelines)	$15.00
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.		
* RELINE, REPAIR, REBASE, AND REPLACE OF THERMOPLASTIC PARTIALS IS COVERED ONLY ON ADVANTAGE PLANS. ON ADVANTAGE PLANS ADD $25 TO LISTED COPAYMENT FOR REPAIRS/RELINES/REBASES OF THERMOPLASTIC/FLEXIBLE BASE FULL AND PARTIAL DENTURES		
D5110	Complete upper denture	$90.00
D5120	Complete lower denture	$90.00
D5130	Immediate upper denture	$90.00
D5140	Immediate lower denture	$90.00
D5211	Upper partial denture - resin base	$125.00
D5212	Lower partial denture - resin base	$125.00
D5213	Upper partial denture - cast metal framework with resin denture bases	$125.00
D5214	Lower partial denture - cast metal framework with resin denture bases	$125.00
D5221	Immediate maxillary partial denture - resin base	$125.00
D5222	Immediate mandibular partial denture - resin base	$125.00
D5223	Immediate maxillary partial denture - metal framework	$125.00
D5224	Immediate maxillary partial denture - metal framework	$125.00
D5225	Upper partial denture - flexible base	$125.00
D5226	Lower partial denture - flexible base	$125.00
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. *	$10.00
D5512	Repair broken complete denture base, maxillary. *	$10.00
D5520	Replace missing or broken teeth - complete denture (each tooth)*	$10.00
D5611	Repair resin denture base, mandibular.*	$10.00
D5612	Repair resin denture base, maxillary.*	$10.00
D5621	Repair cast partial framework, mandibular.	$10.00
D5622	Repair cast partial framework, maxillary.	$10.00
D5630	Repair or replace broken clasp*	$10.00
D5640	Replace partial denture broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture*	$10.00
D5660	Add clasp to existing partial denture*	$10.00
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	$100.00
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	$100.00
D5710	Rebase complete upper denture	$40.00
D5711	Rebase complete lower denture	$40.00
D5720	Rebase upper partial denture	$40.00
D5721	Rebase lower partial denture	$40.00
D5730	Reline complete upper denture (chairside)	$25.00
D5731	Reline complete lower denture (chairside)	$25.00
D5740	Reline upper partial denture (chairside)	$25.00
D5741	Reline lower partial denture (chairside)	$25.00
D5750	Reline complete upper denture (laboratory)*	$25.00
D5751	Reline complete lower denture (laboratory)*	$25.00
D5760	Reline upper partial denture (laboratory)*	$25.00
D5761	Reline lower partial denture (laboratory)*	$25.00
D5820	Interim partial denture (upper)	$40.00
D5821	Interim partial denture (lower)	$40.00
D5850	Tissue conditioning, upper	$10.00
D5851	Tissue conditioning, lower	$10.00
D5876	Add metal substrate to new acrylic full denture (per arch)	$200.00
ALTERNATIVE DENTURES, FULL + PARTIAL, & RELINES		
MOST DENTAL OFFICES OFFER ALTERNATIVES TO STANDARD COMPLETE AND PARTIAL DENTURES AND RELINES WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	Complete Denture	

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CODE	DESCRIPTION	MEMBER COPAYMENT
	Comfort Flex - Complete Upper Denture	$550.00
	Comfort Flex - Complete Lower Denture	$550.00
	Geneva - Complete Upper Denture	$550.00
	Geneva - Complete Lower Denture	$550.00
	Partial Denture - Resin Base	
	Simply Natural/Comfort Flex - Upper Partial	$600.00
	Simply Natural/Comfort Flex - Lower Partial	$600.00
	Geneva - Upper Partial	$600.00
	Geneva - Lower Partial	$600.00
	EstheticClasp - Upper Partial	$600.00
	EstheticClasp - Lower Partial	$600.00
	CuSil - Upper Partial	$600.00
	CuSil - Lower Partial	$600.00
	Valplast - Upper Partial	$600.00
	Valplast - Lower Partial	$600.00
	Partial Denture - Cast Metal Base with Resin Saddles	
	Comfort Flex - Upper Partial	$600.00
	Comfort Flex - Lower Partial	$600.00
	Valplast - Upper Partial	$600.00
	Valplast - Lower Partial	$600.00
	Denture Relines	
	PermaSoft - Complete Upper Denture (Laboratory)	$100.00
	PermaSoft - Complete Lower Denture (Laboratory)	$100.00
	PermaSoft - Partial Upper Denture (Laboratory)	$100.00
	PermaSoft - Partial Lower Denture (Laboratory)	$100.00
D5900 - D5999	**MAXILLOFACIAL PROSTHETICS - NOT COVERED**	
D6000 - D6199	**IMPLANT SERVICES-NOT COVERED**	
FIXED PROSTHODONTICS		
INCLUDES ALL BASES, LINERS, ADHESIVES, BONDING AGENTS, DESENSITIZING AGENTS, REMOVAL OF EXISTING RESTORATIONS, LAB COSTS, AND TEMPORIZATION.		
D6210	Pontic - cast high noble metal	$225.00
D6211	Pontic - cast predominantly base metal	$75.00
D6212	Pontic - cast noble metal	$175.00
D6214	Pontic- titanium (includes porcelain fused to titanium)	$225.00
D6240	Pontic - porcelain fused to high noble metal	$225.00
D6241	Pontic - porcelain fused to predominantly base metal	$75.00
D6242	Pontic - porcelain fused to noble metal	$175.00
624MLR	Pontic- porcelain fused to any metal for molars	Add $75 to nonmolar copayment fee.
D6245	Pontic – porcelain/ceramic	$250.00
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
D6600	Inlay - porcelain/ceramic, 2 surfaces	$195.00
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	$210.00
D6602	Inlay - cast high noble metal, 2 surfaces	$225.00
D6603	Inlay - cast high noble metal, 3 or more surfaces	$275.00
D6604	Inlay - cast predominantly base metal, 2 surfaces	$125.00
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	$175.00
D6606	Inlay - cast noble metal, 2 surfaces	$175.00
D6607	Inlay - cast noble metal, 3 or more surface	$225.00
D6608	Onlay -porcelain/ceramic, 2 surfaces	$195.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$210.00
D6610	Onlay - cast high noble metal, 2 surfaces	$225.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$275.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$125.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$175.00
D6614	Onlay - cast noble metal, 2 surfaces	$175.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$225.00
D6624	Inlay - titanium	$225.00
D6634	Onlay - titanium	$225.00
D6740	Crown-porcelain/ceramic	$225.00
D6750	Crown - porcelain fused to high noble metal	$225.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D6751	Crown - porcelain fused to predominantly base metal	$75.00
D6752	Crown - porcelain fused to noble metal	$175.00
675MLR	Crown-porcelain fused to any metal for Molars	Add $75 to nonmolar copayment fee.
D6780	Crown - 3/4 cast high noble metal	$225.00
D6781	Crown - 3/4 cast predominantly base metal	$75.00
D6782	Crown - 3/4 cast noble metal	$175.00
D6783	Crown - 3/4 porcelain/ceramic	$225.00
D6790	Crown - full cast high noble metal	$225.00
D6791	Crown - full cast predominantly base metal	$75.00
D6792	Crown - full cast noble metal	$175.00
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
D6794	Crown - titanium (includes porcelain fused to titanium)	$225.00
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
D6985	Pediatric partial denture--Fixed, temporary	$180.00
ALTERNATIVE BRIDGE MATERIALS		
MANY DENTAL OFFICES OFFER PREMIUM MATERIALS AS ALTERNATIVES TO THE STANDARD PORCELAIN/CERAMIC SUBSTRATE AND PORCELAIN-FUSED-TO-METAL MATERIALS FOR DENTAL RESTORATIONS, WHICH ARE MARKETED UNDER DIFFERENT BRAND NAMES AND MAY BE AVAILABLE THROUGH YOUR CALIFORNIA DENTAL PARTICIPATING PROVIDER FOR THE FOLLOWING COPAYMENTS. *CROWNS, BRIDGES, INLAYS, AND ONLAYS, FABRICATED IN THESE PREMIUM MATERIAL ALTERNATIVES AND PREPARED AND DELIVERED ON THE SAME DAY ARE SUBJECT TO AN ADDITIONAL $250.00 IN-OFFICE LAB FEE. THIS LIST IS UPDATED REGULARLY-CONTACT THE PLAN FOR AN UP TO DATE LIST OF CURRENTLY COVERED MATERIALS.		
	PORCELAIN/CERAMIC SUBSTRATE CROWN	
	CEREC, Full-Z, Bruxzir, Lava, Prismatik	$645.00
	CEREC Blue Block, e.Max, Procera	$845.00
	Lava (layered), e.Max (layered), Procera (Layered)	$900.00
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
	Captek, Bio-2000	$675.00
	Occlusal Gold, Design, Synspar	$675.00
ORAL SURGERY		
INCLUDES SUTURES AND CLOTTING AGENTS; EXTRACTIONS INCLUDE MINOR SMOOTHING OF BONE.		
D7111	Extraction, coronal remnants - primary tooth	$0.00
D7140	Extraction, erupted tooth or exposed root	$0.00
D7210	Surgical removal of erupted tooth	$0.00
D7220	Removal of impacted tooth - soft tissue	$0.00
D7230	Removal of impacted tooth - partially bony	$0.00
D7240	Removal of impacted tooth - completely bony	$0.00
D7241	Removal of impacted tooth - completely bony, with unusual complications	$0.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$0.00
D7251	Coronectomy - intentional partial tooth removal	$0.00
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	$100.00
D7310	Alveoplasty in conjunction with extractions - 4 or more contiguous teeth per quadrant	$0.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$0.00
D7320	Alveoplasty not in conjunction with extractions - 4 or more contiguous teeth per quadrant	$0.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	$0.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$0.00
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
D8050	Interceptive orthodontic treatment of the primary dentition*	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition*	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition*	$1,975.00

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CODE	DESCRIPTION	MEMBER COPAYMENT
D8660	pre-orthodontic treatment visit examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$0.00
D8680	Orthodontic retention - Per Arch	$125.00
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)	$250.00
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit.	$75.00
	Appliances (head gear, maxillary expansion, etc.) may be required in addition to full banding.	UCR*
ADJUNCTIVE GENERAL SERVICES		
	* - COVERED ONLY FOR THE REMOVAL OF IMPACTED WISDOM TEETH (1,16,17 & 32)	
	# - COVERED ONLY WHEN PERFORMED BY THE MEMBER'S PRIMARY GENERAL DENTIST.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
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
D9222	Deep sedation/general anesthesia – first 15 minutes*	$117.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes*	$85.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	$15.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes*	$100.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes*	$65.00
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.	$25.00
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	$25.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9999	Office visit - during regular office hours in addition to other charges	$0.00
D9630	Other drugs and/or medicaments dispensed in the office for home use.	$15.00
D9910	Application of desensitizing medicament, per visit. (not to be used under restorations)	$15.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth (not to be used under restorations)	$15.00
D9930	Treatment of complication (post-surgical), unusual circumstances, by report	$0.00
D9932	In office cleaning and inspection of removable complete upper denture. Limited to once every 6 months.	$10.00
D9933	In office cleaning and inspection of removable complete lower denture. Limited to once every 6 months.	$10.00
D9934	In office cleaning and inspection of removable partial upper denture. Limited to once every 6 months.	$10.00
D9935	In office cleaning and inspection of removable partial lower denture. Limited to once every 6 months.	$10.00
D9942	Repair/reline occlusal guard	$40.00
D9943	Occlusal guard adjustment. Coverage is limited to only soft guards that are a Plan covered benefit.	$10.00
D9944	occlusal guard – hard appliance, full arch	$250.00
D9945	occlusal guard – soft appliance, full arch	$150.00
D9946	occlusal guard – hard appliance, partial arch	$200.00
D9951	Occlusal adjustment - limited	$15.00
D9961	duplicate/copy patient's records	$25.00
D9972	External bleaching - per arch, performed in office	$250.00
D9973	External bleaching - per tooth	$20.00
D9975	External bleaching for home application- per arch	$125.00
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	$25.00
D9999	Broken Specialist Appointment - less than 24 notice	$40.00

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Specialty Coverage:

A75 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "LS" after the Plan number on their identification card, or, for Advantage plans those that have NO suffix on the plan number, and they are limited to $1,000 in benefits paid by the Plan on the Member's behalf per Member 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 benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A75S 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 costs of services provided by a contracted dental specialist in excess of the Member's listed copayments (which are due and payable by the Member at the time of service) are covered benefits for Members with an "S" after the Plan number on their identification card, and the Member will pay the copayment amounts listed on their plan benefit schedule with no annual maximum. Pedodontic specialty services are covered at a 50% discount off of the specialist's UCR fees on covered, approved, services up to $500 in benefits paid by the Plan on the Member's behalf per Member per year, and then a 30% discount from the specialist's UCR fee on covered, approved, services listed above thereafter.

A75V 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.

EXCLUSIONS AND LIMITATIONS

Some limitations and exclusions are waived for Members on Advantage Plans. See 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.

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- Expenses incurred in connection with any dental procedure started prior to the effective date of Coverage or after the termination date of Coverage.
- Hospital costs of any kind.
- Loss or theft of full or partial dentures.
- Any procedures or appliances for the purpose of correcting contour, contact, occlusion or to change vertical dimension.
- Damage to teeth due to mouth jewelry, for example tongue piercing.
- Services of a prosthodontist.

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (sub-gingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, the fixed bridge is considered optional treatment.
- Replacement of partial dentures is limited to once every five years from initial placement while the member is covered by the plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement while the member is covered by the plan. Replacement will be provided by CDN for an existing full or partial denture only if it is unserviceable and cannot be made serviceable by either reline or repair.
- Denture relines are limited to one per arch in any 12-month period.
- Sealants when covered are limited to permanent first and second molars.
- Replacement of a restoration is covered only when dentally necessary.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- 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 to a maximum of $500 per Member per year.
- 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.

Principal Benefits & Coverage Plan A75

- 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®).

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.

California Dental Network, Inc is licensed by the California
Department of Managed Health Care under
the Knox Keene Health Care Service Plan Act (License number 933-0286).

UPGRADING TREATMENT

If a Member selects a more expensive form of treatment than is considered the covered benefit under their dental plan, the Member must pay the difference between the attending California Dental Network provider's UCR fees for the upgraded treatment and the covered treatment PLUS the co-payment for the covered treatment.

EXAMPLE:

Upgraded Treatment UCR fee	4 Unit Bridge	$2,400.00
LESS (-)		
Covered Benefit UCR fee	Partial Denture	- $1,000.00
		$1,400.00
PLUS (+)		
Covered Benefit Co-payment	Partial Denture	+ 90.00
EQUALS (=)		
Member Responsibility		$1,490.00

The plan does not compensate providers for lab reimbursement when they have charged Members for upgraded or optional treatment; see the section on **PROVIDER COMPENSATION** for details of lab reimbursement.

UPGRADED & OPTIONAL / NON-COVERED TREATMENT FORM

PLAN____________________________________

		Plan Covered Treatment (do not leave blank)				Upgraded Treatment				Optional/Non-Covered Treatment			**Patient Accepts & Is Responsible For**		
Tooth No.	Existing Condition	ADA* Code	Description	Office UCR**-**A**	Pt. Pays Plan Copay-**B**	ADA* Code	Description	Office UCR**-**C**	Patient Pays (C-A) + B***	ADA Code	Description	Patient Pays Entire UCR**	**ADA* Code**	**Description**	**Fee**
3	Decay	2160	MOD Amalgam	$150.00	0	2387	MOD Composite	$270.00	$120.00	2663	Resin Onlay	$900.00	2387	MOD Composite	$120.00
11			Partial			6721	Four	$1,000.00		5225	Removable		5225	Removable	
12	Missing	5213	Denture	$1,400.00	$50.00	6241	Unit	$1,000.00	$2,650.00	5225	Partial	$1,300.00	5225	Partial	$1,300.00
13	Missing		with			6241	Fixed	$1,000.00		5225	Denture		5225	Denture	
14			Metal Framework			6721	Bridge	$1,000.00		5225	w/ Flexible Base		5225	w/ Flexible Base	
			Example of Totals	$1,550.00	$50.00			**Examples of Computing Alternatives**						**Example of Total**	$1,420.00
			Total Cost of Covered Treatment Plan											**Total Cost for Accepted Treatment (Patient Responsibility)**	

*ADA Code is the code for procedures as defined by the American Dental Association. Note: Your dentist may recommend treatments for which there is presently no ADA Code.
**UCR - Usual, Customary & Reasonable dental office fee
***Computation formula for upgraded treatment: UCR of Upgraded Treatment (Column C) - UCR of Covered Treatment (Column A) + Copayment for Covered Treatment (Column B) = Cost to Patient

I have accepted a treatment plan that may include upgraded and/or optional treatments that have limited or no coverage by my dental plan. My treatment plan has been fully explained to me in terms that I understand and any questions I have about my treatment have been answered before starting treatment. I understand the availability of plan covered treatments and their costs and, by my signature below, I agree to be responsible for the additional costs of any upgraded and/or optional treatments I have accepted.

Patient Signature ____________________________________ Date ________

DO NOT SIGN IF YOU HAVE ANY UNRESOLVED QUESTIONS ABOUT PLAN COVERAGE OR FEES. FOR ASSISTANCE CONTACT CALIFORNIA DENTAL NETWORK MEMBER SERVICES.

GUIDELINES FOR GENERAL DENTISTS

Eligibility

California Dental Network

A DentaQuest company

ELIGIBILITY

At the time of enrollment, potential Subscribers select a participating provider from a list provided by California Dental Network. Once enrolled, Subscribers* receive the following:

- **IDENTIFICATION (ID) CARD**
  One ID card per Subscribing family is issued. It contains pertinent information, such as Subscriber name, ID number, effective date of coverage, the Subscriber's plan number, the selected dental office, and covered dependents, if any. A sample ID card, showing the areas where this important information can be found, is at the back of this section for your reference.

  The ID card is not a guarantee of coverage or proof of eligibility because a subscriber's employment or coverage can terminate at any time after the card is issued.

- **EVIDENCE OF COVERAGE AND DISCLOSURE FORM**
  The Evidence of Coverage and Disclosure Form details the terms and conditions of the Member's coverage, including the Limitations and Exclusions, and the Plan's grievance procedures. Note: some Limitations and Exclusions are modified or waived for Members with Advantage Plans and Cosmetic Riders. See Clinical Guidelines.

- **PRINCIPAL BENEFITS & COVERAGE**
  The Principal Benefits & Coverage schedule details the covered services under the Member's plan and sets forth the applicable Member co- payments for each covered procedure. Copies of the Principal Benefits & Coverage for each California Dental Network plan are included in the **BENEFITS** section of this manual.

* Subscribers and their dependents are all considered by the Plan to be "Members" or "Enrollees".

Member benefits are effective the first of the month and can be verified by one of three ways:

- **COVERAGE ROSTER BY FACILITY**
  Each month your office will receive an alphabetical listing of the Members who are eligible to receive services at your facility. It will be sent to your office at the beginning of each month. It reflects eligible Members for that month. *Example:* A roster dated August 1 should be received by your office before the 5th of August and will reflect those Members eligible for services in your office during the month of August. Please note that individual and group

Members are shown separately on these rosters. Refer to the sample roster at the end of this section. California Dental Network guarantees capitation will be paid for all Members listed on the eligibility roster, regardless of the listed "paid through" date. The "pd thru date" and "curr date" on the roster are not to be used to determine eligibility for services.

- **PHONE ELIGIBILITY**
  Contact the Plan's Customer Service Department toll-free at (877) 4-DENTAL (433-6825) to obtain the eligibility status for anyone not appearing on your latest roster. Please have the Member's name, identification number and group name, if applicable, ready for the customer service representative to quickly verify member eligibility.

- **WEBSITE ELIGIBILITY**
  Visit **www.caldental.net** and register your office as a CDN Provider on the Provider section of the website. You will need your four-digit Provider number and the Federal Tax ID number that you supplied to CDN with your application for membership.

Coverage is terminated on the last day of the month following the date when:

- The subscriber changes employment,
- The Member moves out of the plan network area, or
- A dependent changes status.

Remember to refer to your eligibility roster, call our Customer Service Department, or visit www.caldental.net to avoid treating patients no longer covered on the Plan.

If a Member informs your office that their California Dental Network coverage will end due to termination of employment and asks if the coverage can continue, advise the Member to contact their benefits department to request information through COBRA. COBRA members have the same benefits and co-payments as their employer group.

If the Member does not qualify for COBRA, or is no longer eligible for COBRA benefits, they may convert to an individual plan offered by California Dental Network. COBRA members and Members who have converted to individual plans will reflect on your eligibility roster in the same way as other Members.

GUIDELINES FOR GENERAL DENTISTS

Member Transfers

California Dental Network

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MEMBER TRANSFER REQUESTS

If a Member wishes to change their selected provider, he or she may do so by:

- Calling the Plan's Customer Service Department toll-free at (877) 4-DENTAL (433-6825) or
- Writing a letter to the Plan's Customer Department requesting a transfer.

If a provider wishes to transfer a Member out of their office, he or she may do so by:

- Writing a letter to the Plan's Customer Department requesting a transfer.
  - Send to: California Dental Network
    23291 Mill Creek Dr. Ste 100
    Laguna Hills, CA 92653
- Faxing a letter to the Plan's Customer Department requesting a transfer (949) 830-1655.
- The provider must inform the Member of the decision to discontinue treatment in the same manner as any other patient of his or her practice and in compliance with the provisions of the Dental Practice Act for completion of treatment in progress, records transfer, and support care during transition to a new provider.

TRANSFER GUIDELINES

- A Member may transfer from one dental office to another dental office, effective the first day of the month following the request.
- The entire family must transfer as a unit.
- All outstanding balances for covered treatment must be cleared. If a Member has an overdue balance for covered treatment, and you wish to prevent a transfer, please call and inform the Plan.
- Member eligibility should be confirmed prior to scheduling any appointments.

In emergency situations, the Plan will contact the provider with verification of eligibility.

GUIDELINES FOR GENERAL DENTISTS

ID Cards, Rosters, and Facility Payment Summaries

California Dental Network

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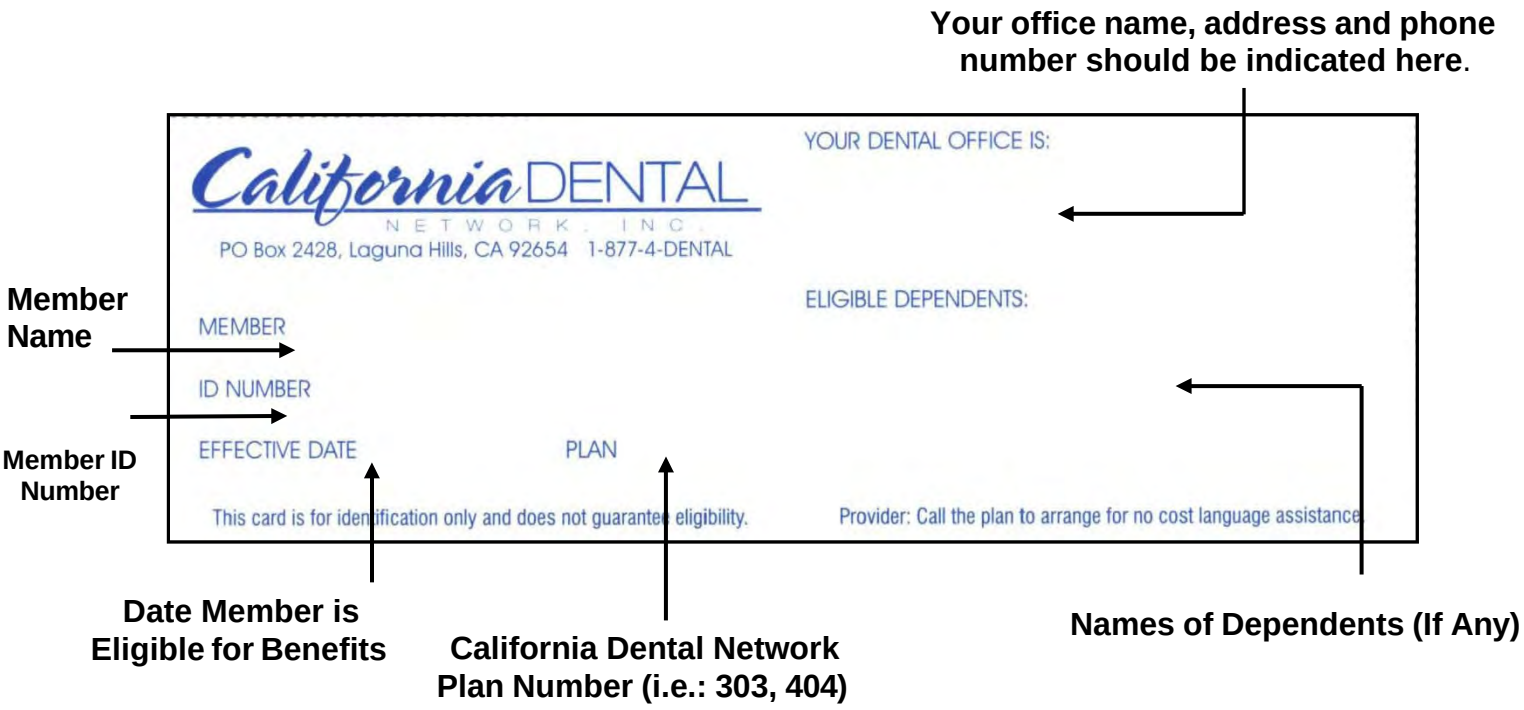
MEMBER ID CARD



California Dental Network, Inc. COVERAGE ROSTER BY FACILITY
05/01/2005
Alternative Dental PAGE 1

FACILITY: 00009999 LEHTAH DDS, ARLO

Name.....	Benefit Plan	Eff. Date	Pd Thru Date	Amt Paid	IND/GRP	ID Number
GARCIA, DAVID A	411	01/99	03/06	00.00	I00006	0301257849
PHILLIPS, JOSEPH	411	01/99	02/06	6.50	I00041	0211575690
RUSSELL, PHYLLIS	430	01/05	05/05	0.00	I000056	0309230015
MESA					05/10/74	
DOE, JOHN	505S	04/99	06/05	8.30	G000199	0210025486
JANE					06/21/85	
SMITH, RICHARD	303S	05/99	04/05	12.25	G000691	0210001668
SUSAN					11/23/69	
JOSHUA					01/22/85	
CHRISTOPHER					03/13/79	

California Dental Network, Inc. FACILITY PAYMENT SUMMARY Date 01/06/99
Alternative Dental PAGE 1 AsOf 02/01/05

9999 LEHTAH DDS, ARLO
66 ROUTE ST
SUNNY CA 90099

	PAID FOR			PLAN	#MO	PAID	PD THRU
I	00006	0301257849	GARCIA, DAVID	411	1	00.00	04/01/05
I	00041	0211575690	PHILLIPS, JOSEPH	411	1	6.50	04/01/05
I	00056	0309230015	RUSSELL, PHYLLIS	430	1	00.00	04/01/05
G	000199	0309230015	DOE, JOHN	505S	1	8.30	04/01/05
G	000691	0210001668	SMITH, RICHARD	303S	1	12.25	04/01/05

TOTAL: 26.05

REMEMBER—LOGON to our Website at – www.caldental.net
For COMPLETE Fee listings and other information.

GUIDELINES FOR GENERAL DENTISTS

Encounter Data

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PATIENT ENCOUNTER DATA

(UTILIZATION REPORTING)

California Dental Network, Inc. requires submission of patient encounter data only for those covered procedures that you render to California Dental Network members. Submission of patient encounter information is extremely important for the following reasons:

- Statistical Reports for Employer Groups: The utilization data is compiled to satisfy the needs of customers and plays an important role in renewals and rate settings.

- Statistical Reports for California Dental Network:
    - Management reports establish the norms for utilization and referral patterns.
    - Help in the development of utilization patterns on which to base future compensation rates to network providers.
    - Help in the future development of benefit plans.

- Encounter data should be submitted to California Dental Network quarterly via the following formats:

    - Universal Claim Form.*
    - Computer printout with data equivalent to Claim Form information.

*Please indicate clearly that the form is encounter data so that it will not be processed as a claim.

GUIDELINES FOR GENERAL DENTISTS

Provider Compensation

California Dental Network

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PROVIDER COMPENSATION

California Dental Network has designed a variety of dental benefit plans that compensate providers in one or more of the following ways:

- **CAPITATION**
  A payment based upon a percentage of premiums collected by the plan for each Member assigned to your office, and that is paid to you regardless of whether the Member utilized your services during the month. Capitation payments vary by benefit plan and size of the group. The range of capitation for each benefit plan is set forth in your provider contract. Capitation payments are made on the first of each month and provide your office with a steady cash flow that is not dependent upon member utilization. A sample Facility Payment Summary showing what you will receive with each capitation payment is included in the Eligibility Section of this manual.

- **CO-PAYMENT**
  A fee for service payment made directly to you by the Member for the services you render. Co-payments are pre-determined amounts for each procedure that is covered under Member's benefit plan. Co-payments for each plan are set forth in the Principal Benefits & Coverage schedules contained in the BENEFITS section of this manual. Co-payments are due under the plan at the time services are rendered.

- **LAB REIMBURSEMENT & CLAIM SUBMISSION**
  California Dental Network will reimburse you for a portion of your laboratory costs for crowns, bridges and dentures provided to ***group members on Plans*** . ***Advantage Plans*** according to the following schedule:

Procedure	Reimbursement
Crown, per unit	$100.00
Bridge, per unit	$100.00
Denture, per arch	$180.00
Partial Denture, per arch	$180.00

  Reimbursement of lab costs can be obtained by submitting the following to California Dental Network:
  - A copy of your lab bill that details the charges, and
  - Patient encounter forms for both the prep and the fitting service dates.

  All Lab and Specialty Provider claims should be submitted to California Dental Network at 23291 Mill Creek Drive, Suite 100, Laguna Woods, CA 92653.

If you have any questions regarding your capitation payment, the amount of a Member's co-payment, or how to get lab or specialty care reimbursement, please feel free to call our Provider Relations department toll free at 877 4DENTAL (433-6825).

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Dental Services Agreement for General Dentist

Schedule A-1

Capitation Schedule for DHMO Members

This Schedule A-1 sets forth the DENTIST's compensation under the Dental Services Agreement for General Dentist by and between California Dental Network, Inc. (CDN) and the DENTIST listed below for Members enrolled in any CDN Benefit Plan Listed.

Advantage Plans

The Member Copayments are subject to Addendum 1 to Attachment A, which sets forth the Minimum Guarantee for DHMO Members enrolled in a CDN Advantage Plan (A75, A100, A150, A200, A250).

The Plan copayment schedules may be updated, amended, or revised by CDN at any time and shall be effective 30 days after written notice to DENTIST.

Capitation Payment	A75*	A100*	A150*	A200*	A250*
Per Member Per Month	$3.50	$3.00	$2.50	$2.25	$2.00

*The Plan will reimburse Crown, Bridge and Denture lab costs under group plans to the following maximums for covered benefits other than alternative or premium materials: Crowns & Bridges, per unit, $100.00; Dentures & Partials, $180.00.

Individual Plans

Capitation Payment	411	595
Individual	$6.50	$4.75
Couple	$8.50	$7.25
Family	$11.50	$10.00

Plan 460 is a Discounted Fee-For-Service Plan which is a co-payment only, non-capitated plan.

California Dental Network

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Addendum to Attachment A to the Dental Services Agreement for General Dentist
Minimum Procedural Guarantee
for DHMO Members enrolled in Advantage Plans

Dental Office Name: _____ Owner Dentist: _____

This Addendum to Attachment A to the Dental Services Agreement for General Dentists by and between California Dental Network, Inc. (CDN) and the DENTIST listed above supersedes all other Attachment A(s) as it relates to dentist's compensation for DHMO Group Members enrolled in CDN Advantage Plans (A75, A100, A150, A200, A250), as follows:

1. **Monthly Capitation:**

Monthly, Dentist shall be paid a fixed fee or capitation for each member who has selected or been assigned to Dentist's office, provided the Member's premiums have been paid. Capitation is not dependent upon the Dentist providing care to the Member that month. Capitation will be paid in accordance with the attached Schedule (Schedule A-1 Attached).

2. **Fee for Service**

In addition to the capitation payments paid by CDN for Advantage Group members, CDN does hereby agree to pay DENTIST a Minimum Guarantee for the procedures contained herein **LESS** the amount of the Member's applicable copayment, where the service is a covered benefit under the Member's Evidence of Coverage and the Member is eligible at the time of service.

In order to receive payment under this Minimum Copayment Guarantee, DENTIST must submit a claim or encounter data in a format acceptable to CDN within 180 days of the member's treatment. CDN shall pay the DENTIST within 30 days of the month end of receipt of a complete claim or equivalent data.

The procedures listed herein and the amounts of the Minimum Copayment Guarantee for those procedures may be updated, amended, or revised by CDN at any time and shall be effective 45 days after written notice to DENTIST.

Code	Description of Services	Minimum Guarantee
120	Periodic oral evaluation	$2.00
150	Comprehensive oral evaluation - new or established patient	$2.00
1110	Prophylaxis - adult	$3.50
1120	Prophylaxis - child	$3.50
1351	Sealant - per tooth	$5.00
1352	Preventive Resin Restoration	$5.00
2391	Resin-based composite - 1 surface, posterior.	$70.00
2392	Resin-based composite - 2 surfaces, posterior	$100.00
2392	Posterior Composite	$100.00
2393	Posterior Composite	$125.00
2393	Resin-based composite - 3 surfaces, posterior	$125.00
2394	Posterior Composite	$150.00
2394	Resin-based composite - 4 or more surfaces, posterior	$150.00
2740	Crown - porcelain/ceramic substrate	$350.00
2750	Crown - porcelain fused to high noble metal	$400.00
2751	Crown - porcelain fused to predominantly base metal	$250.00

2752	Crown - porcelain fused to noble metal	$350.00
2780	Crown - 3/4 cast high noble metal	$400.00
2781	Crown - 3/4 cast predominantly base metal	$250.00
2782	Crown - 3/4 cast noble metal	$275.00
2783	Crown - 3/4 porcelain/ceramic	$300.00
2790	Crown - full cast high noble metal	$375.00
2791	Crown - full cast predominantly base metal	$250.00
2792	Crown - full cast noble metal	$325.00
2794	Crown-Titanium, Includes full titanium and porcelain fused to titanium	$275.00
3310	Root canal - anterior per tooth	$100.00
3320	Root canal - bicuspid per tooth	$120.00
3330	Root canal - molar per tooth	$275.00
4341	Periodontal scaling and root planing - four or more teeth per quadrant	$35.00
4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30.00
4355	Full Mouth Debridement	$25.00
4910	Periodontal maintenance - once every 6 months	$30.00
5110	Complete upper denture	$300.00
5120	Complete lower denture	$300.00
5130	Immediate upper denture	$300.00
5140	Immediate lower denture	$300.00
5211	Upper partial denture - resin base	$250.00
5212	Lower partial denture - resin base	$250.00
5213	Upper partial denture - cast metal framework with resin denture bases	$250.00
5214	Lower partial denture - cast metal framework with resin denture bases	$250.00
5225	Upper partial denture - flexible base	$250.00
5226	Lower partial denture - flexible base	$250.00
6210	Pontic - cast high noble metal	$400.00
6211	Pontic - cast predominantly base metal	$250.00
6212	Pontic - cast noble metal	$350.00
6240	Pontic - porcelain fused to high noble metal	$300.00
6241	Pontic - porcelain fused to predominantly base metal	$250.00
6242	Pontic - porcelain fused to noble metal	$350.00
6245	Pontic – porcelain/ceramic	$250.00
6250	Pontic - resin with high noble metal	$325.00
6740	Crown-porcelain/ceramic	$350.00
6750	Crown - porcelain fused to high noble metal	$400.00
6751	Crown - porcelain fused to predominantly base metal	$250.00
6752	Crown - porcelain fused to noble metal	$350.00
6780	Crown - 3/4 cast high noble metal	$300.00
6781	Crown - 3/4 cast predominantly base metal	$250.00
6782	Crown - 3/4 cast noble metal	$250.00
6783	Crown - 3/4 porcelain/ceramic	$300.00
6790	Crown - full cast high noble metal	$300.00

6791	Crown - full cast predominantly base metal	$250.00
6792	Crown - full cast noble metal	$250.00

GUIDELINES FOR GENERAL DENTISTS

Covered California

California Dental Network

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California Dental Network

A DentaQuest company

Administrative Guidelines for General Dentists:

Information for Providers Treating California Dental Network Covered California Members

INTRODUCTION

Our company mission is "To Improve the Oral Health of All". We do this by partnering with our quality provider network, to provide unparalleled member service to support the triple-aim of healthcare: improving the member experience, improving member health, and reducing costs.

California Dental Network is one of the approved stand-alone dental plans selected to administer dental benefits to Individuals and Small Groups in the Covered California program effective January 1, 2017. CDN also has partnerships with Molina Healthcare of California and Ventura County Health Care Plan to administer a plan for pediatric members that fulfills the requirement for pediatric dental essential health benefits under the Affordable Care Act.

As a result, Members will be seen at your office under the following plans:

ID Card/Roster Name	Plan Name
CC17GrF	California Dental Network Family Dental HMO (Group 2017)
CC17GrC	California Dental Network Children's Dental HMO (Group 2017)
CC17InF	California Dental Network Family Dental HMO (Individual 2017)
CC17MHC	Molina Healthcare of California Child Only Dental Plan
VCHCP1	Ventura County Health Care Plan Child Only Dental Plan

Each of these plans features the same benefit for children, with an adult benefit available only to members on the Family Dental HMO Plans.

CONTACT INFORMATION

Provider Services
California Dental Network
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653
877-433-6825 Ext 1201
Provider Services E-mail: Provider.relations@caldental.net
Provider Services Fax: 949-398-0041

Customer Service/Member Services
CALIFORNIA DENTAL NETWORK: 855-425-4164

Request for Authorizations should be sent to:
CALIFORNIA DENTAL NETWORK - Authorizations
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653

Credentialing
CALIFORNIA DENTAL NETWORK:
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
877-433-6825 ext 1242

CLAIMS SUBMISSION

Paper Claims should be sent to:
CALIFORNIA DENTAL NETWORK- Claims
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653
Fax: 657-235-0145

ELIGIBILITY

At the time of enrollment, potential Subscribers select a participating provider from a list provided by California Dental Network. Once enrolled, Subscribers* receive the following:

IDENTIFICATION (ID) CARD

One ID card per Subscribing family is issued. It contains pertinent information, such as Subscriber name, ID number, effective date of coverage, the Subscriber's plan number, the selected dental office, and covered dependents, if any. A sample ID card, showing the areas where this important information can be found, is at the back of this section for your reference.

The ID card is not a guarantee of coverage or proof of eligibility because a subscriber's coverage can terminate at any time after the card is issued.

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

The Evidence of Coverage and Disclosure Form details the terms and conditions of the Member's coverage, including the Limitations and Exclusions, and the Plan's grievance procedures.

BENEFITS & COVERAGE

The Benefits & Coverage schedule details the covered services under the Member's plan and sets forth the applicable Member copayments for each covered procedure. Copies of the Benefits & Coverage for each California Dental Network Covered California Plan are included in the BENEFITS section of this manual.

* Subscribers and their dependents are all considered by the Plan to be "Members" or

"Enrollees".

Member benefits are effective the first of the month and can be verified by one of three ways:

COVERAGE ROSTER BY FACILITY

Each month your office will receive an alphabetical listing of the Members who are eligible to receive services at your facility. It will be sent to your office at the beginning of each month. It reflects eligible Members for that month. Example: A roster dated August 1 should be received by your office before the 5th of August and will reflect those Members eligible for services in your office during the month of August. Please note that individual and group Members are shown separately on these rosters. Refer to the sample roster at the end of this section. California Dental Network guarantees capitation will be paid for all Members listed on the eligibility roster, regardless of the listed "paid through" date. The "pd thru date" and "curr date" on the roster are not to be used to determine eligibility for services.

PHONE ELIGIBILITY

Contact the Plan's Customer Service Department toll-free at (877) 4-DENTAL (433-6825) to obtain the eligibility status for anyone not appearing on your latest roster. Please have the Member's name,

identification number and group name, if applicable, ready for the customer service representative to quickly verify member eligibility.

WEBSITE ELIGIBILITY

Visit www.caldental.net and register your office as a CDN Provider on the Provider section of the website. You will need your four-digit Provider number and the Federal Tax ID number that you supplied to CDN with your application for membership.

Coverage is terminated on the last day of the month following the date when:

- The subscriber changes employment,
- The Member moves out of the plan network area, or
- A dependent changes status.

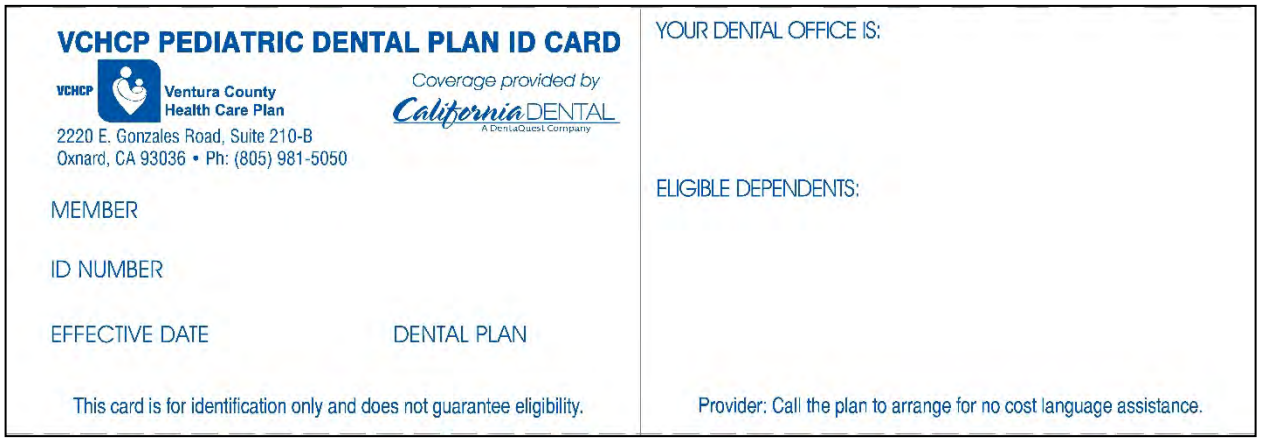
Remember to refer to your eligibility roster, call our Customer Service Department, or visit www.caldental.net to avoid treating patients no longer covered on the Plan. If a Member informs your office that their California Dental Network coverage will end due to termination of employment and asks if the coverage can continue, advise the Member to contact their benefits department to request information through COBRA.

COBRA members have the same benefits and co-payments as their employer group. If the Member does not qualify for COBRA, or is no longer eligible for COBRA benefits, they may convert to an individual plan offered by California Dental Network. COBRA members and Members who have converted to individual plans will reflect on your eligibility roster in the same way as other Members.

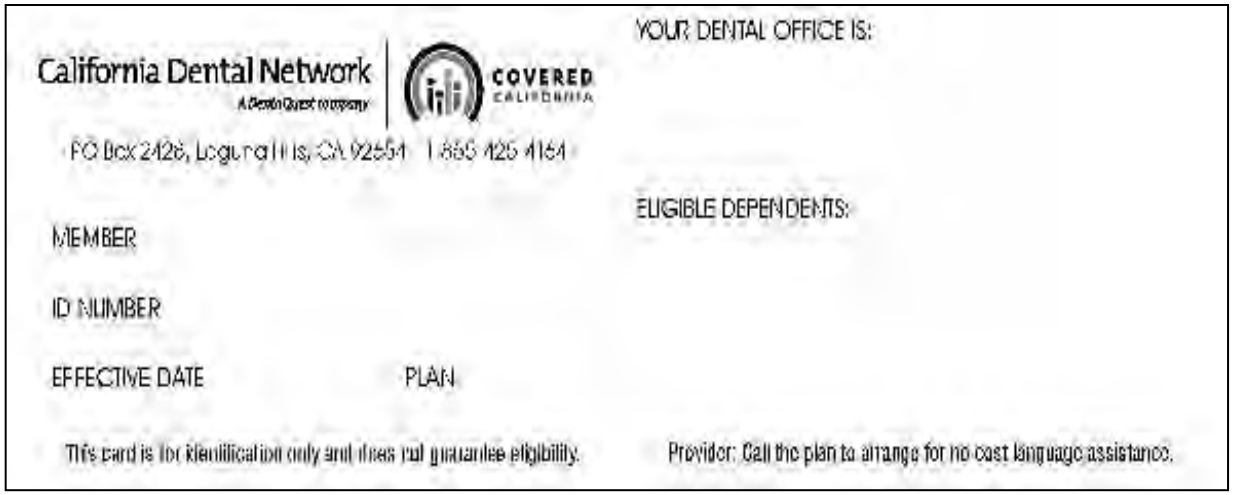
SAMPLE MEMBER IDENTIFICATION CARDS

Members on Molina Healthcare of California Child Only Dental Plan will present with this card:

Ventura County Health Care Plan Child Only Dental Plan will present with this card:



All other Covered California Members will present with the California Dental Network Card:



California Dental Network
A DentaQuest company

COVERED CALIFORNIA

PO Box 2426, Laguna Hills, CA 92654 1-855-425-4164

YOUR DENTAL OFFICE IS:

ELIGIBLE DEPENDENTS:

MEMBER

ID NUMBER

EFFECTIVE DATE PLAN

This card is for identification only and does not guarantee eligibility.

Provider: Call the plan to arrange for no cost language assistance.

Member Copayment Schedule 2024
California Dental Network Family Dental HMO

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

		Member Copayment	
Code	**Description**	**Child (up to Age 19)**	**Adult (Age 19 and older)**
Diagnostic			
D0120	periodic oral evaluation	No Charge	No Charge
D0140	limited oral evaluation	No Charge	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge	Not Covered
D0150	comprehensive oral evaluation	No Charge	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge	No Charge
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	No Charge	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge	No Charge
D0180	Comprehensive periodontal evaluation	No Charge	No Charge
D0190	screening of a patient	Not Covered	No Charge
D0191	assessment of a patient	Not Covered	No Charge
D0210	intraoral - comprehensive series of radiographic images	No Charge	No Charge
D0220	intraoral - periapical first film	No Charge	No Charge
D0230	intraoral - periapical each additional film	No Charge	No Charge
D0240	intraoral - occlusal film	No Charge	No Charge
D0250	Extraoral - first film	No Charge	No Charge
D0251	Extra-oral posterior dental radiographic image	No Charge	Not Covered
D0270	bitewing - single film	No Charge	No Charge
D0272	bitewings - two films	No Charge	No Charge
D0273	Bitewings - three films	No Charge	No Charge
D0274	bitewings - four films - limited to 1 series every 6 months	No Charge	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge	No Charge
D0310	Sialography	No Charge	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge	No Charge
D0322	Tomographic survey	No Charge	No Charge
D0330	panoramic film	No Charge	No Charge
D0340	Cephalometric radiographic image	No Charge	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No Charge	No Charge
D0419	Assessment of salivary flow by measurement	Not Covered	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	No Charge
D0460	pulp vitality tests	No Charge	No Charge

Member Copayment Schedule 2024
California Dental Network Family Dental HMO

D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge	No Charge
D0502	Other oral pathology procedures, by report	No Charge	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge	No Charge
D0701	Panoramic radiographic image – image capture only	No Charge	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only	No Charge	No Charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No Charge	Not Covered
D0706	Intraoral – occlusal radiographic image – image capture only	No Charge	No Charge
D0707	Intraoral – periapical radiographic image – image capture only	No Charge	No Charge
D0708	Intraoral – bitewing radiographic image – image capture only	No Charge	No Charge
D0709	Intraoral – complete series of radiographic images – image capture only	No Charge	No Charge
D0801	3D dental surface scan - direct	No Charge	No Charge
D0802	3D dental surface scan - indirect	No Charge	No Charge
D0803	3D facial surface scan - direct	No Charge	No Charge
D0804	3D facial surface scan - indirect	No Charge	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge	No Charge
Preventive			
D1110	prophylaxis - adult	No Charge	No Charge
D1120	prophylaxis - child	No Charge	Not Covered
D1206	topical fluoride varnish	No Charge	No Charge
D1208	topical application of fluoride	No Charge	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge	No Charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, andsystemic health effects associated with high-risk substance use	No Charge	No Charge
D1330	oral hygiene instructions	No Charge	No Charge
D1351	sealant - per tooth	No Charge	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge	Not Covered
D1353	Sealant repair – per tooth	No Charge	No Charge
D1354	Interim caries arresting medicament application—per tooth	No Charge	No Charge
D1355	Caries preventive medicament application – per tooth	No Charge	No Charge
D1510	space maintainer - fixed – unilateral -per quadrant	No Charge	No Charge
D1516	space maintainer - fixed – bilateral, maxillary	No Charge	No Charge
D1517	space maintainer - fixed – bilateral, mandibular	No Charge	No Charge
D1520	Space maintainer-removable – unilateral- per quadrant	No Charge	No Charge
D1526	space maintainer - removable – bilateral, maxillary	No Charge	No Charge
D1527	space maintainer - removable – bilateral, mandibular	No Charge	No Charge
D1551	Re-cement or re-bond bilateral space maintainer-maxillary	No Charge	No Charge
D1552	Re-cement or re-bond bilateral space maintainer- mandibular	No Charge	No Charge

Member Copayment Schedule 2024
California Dental Network Family Dental HMO

D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	No Charge	No Charge
D1556	Removal of fixed unilateral space maintainer-per quadrant	No Charge	No Charge
D1557	Removal of fixed space maintainer-maxillary	No Charge	No Charge
D1558	Removal of fixed space maintainer-mandibular	No Charge	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral, per quadrant	No Charge	No Charge
Restorative			
D2140	amalgam - one surface permanent or primary	$25	$25
D2150	amalgam - two surfaces permanent or primary	$30	$30
D2160	amalgam - three surfaces permanent or primary	$40	$40
D2161	amalgam - four or more surfaces permanent or primary	$45	$45
D2330	resin-based composite - one surface, anterior	$30	$30
D2331	resin-based composite - two surfaces, anterior	$45	$45
D2332	resin-based composite - three surfaces, anterior	$55	$55
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	$60
D2390	Resin based composite crown, anterior	$50	$50
D2391	Resin based composite - one surface, posterior	$30	$30
D2392	Resin based composite - two surfaces, posterior	$40	$40
D2393	Resin based composite - three surfaces, posterior	$50	$50
D2394	Resin based composite - four or more surfaces, posterior	$70	$70
D2542	onlay - metallic-two surfaces	Not Covered	$185
D2543	onlay - metallic-three surfaces	Not Covered	$200
D2544	onlay - metallic-four or more surfaces	Not Covered	$215
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	$250
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	$275
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	$300
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$160
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$180
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$200
D2710	crown - resin-based composite laboratory	$140	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190	$200
D2720	Crown - resin with high noble metal	Not Covered	$300
D2721	Crown - resin with predominantly base metal	$300	$300
D2722	Crown - resin with noble metal	Not Covered	$300
D2740	crown - porcelain/ceramic	$300	$300
D2750	crown - porcelain fused to high noble metal	Not Covered	$300
D2751	crown - porcelain fused to predominantly base metal	$300	$300
D2752	crown - porcelain fused to noble metal	Not Covered	$300
D2753	crown - porcelain fused to titanium and titanium alloys	Not Covered	$300
D2780	Crown - 3/4 cast high noble metal	Not Covered	$300
D2781	crown - 3/4 cast predominantly base metal	$300	$300
D2782	Crown - 3/4 cast noble metal	Not Covered	$300
D2783	Crown – 3/4 porcelain/ceramic	$310	$310
D2790	crown - full cast high noble metal	Not Covered	$300
D2791	crown - full cast predominantly base metal	$300	$300
D2792	crown - full cast noble metal	Not Covered	$300
D2794	crown - titanium and titanium alloys	Not Covered	$300

Member Copayment Schedule 2024
California Dental Network Family Dental HMO

D2910	Recement inlay, onlay or partial coverage restoration	$25	$25
D2915	Recement cast or prefabricated post and core	$25	$25
D2920	Recement crown	$25	$15
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120	Not Covered
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not Covered
D2930	prefabricated stainless steel crown - primary tooth	$65	Not Covered
D2931	prefabricated stainless steel crown - permanent tooth	$75	$75
D2932	Prefabricated resin crown	$75	Not Covered
D2933	Prefabricated stainless steel crown with resin window	$80	Not Covered
D2940	protective restoration	$25	$20
D2941	Interim therapeutic restoration – primary dentition	$30	Not Covered
D2949	Restorative foundation for an indirect restoration	$45	Not Covered
D2950	Core buildup, including any pins	$20	$20
D2951	pin retention - per tooth, in addition to restoration	$25	$20
D2952	post and core in addition to crown, indirectly fabricated	$100	$60
D2953	Each additional indirectly fabricated post, same tooth	$30	$30
D2954	prefabricated post and core in addition to crown	$90	$60
D2955	Post removal	$60	Not Covered
D2957	Each additional prefabricated post - same tooth	$35	$35
D2971	Additional procedures to customize crown to fit under an existing partial denture framework	$35	Not Covered
D2980	crown repair, by report	$50	$50
D2999	Unspecified restorative procedure, by report	$40	$40
Endodontics			
D3110	pulp cap - direct (excluding final restoration)	$20	$20
D3120	Pulp cap (indirect) excluding final restoration	$25	$25
D3220	therapeutic pulpotomy (excluding final restoration)	$40	$35
D3221	Pulpal debridement, primary and permanent teeth	$40	$50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55	Not Covered
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55	Not Covered
D3310	root canal therapy, anterior tooth (excluding final restoration)	$195	$200
D3320	root canal therapy, premolar tooth (excluding final restoration)	$235	$235
D3330	root canal therapy, molar tooth(excluding final restoration)	$300	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	$85
D3333	Internal root repair of perforation defects	$80	$80
D3346	retreatment of previous root canal therapy - anterior	$240	$245
D3347	retreatment of previous root canal therapy - premolar	$295	$295
D3348	retreatment of previous root canal therapy - molar	$350	$350
D3351	apexification/recalcification – initial visit	$85	$85
D3352	apexification/recalcification - interim	$45	$50

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California Dental Network Family Dental HMO

D3410	apicoectomy/periradicular surgery - anterior	$240	$240
D3421	apicoectomy/periradicular surgery - premolar (first root)	$250	$250
D3425	apicoectomy/periradicular surgery - molar (first root)	$275	$275
D3426	Apioectomy / periradicular surgery - molar, each additional root	$110	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350	Not Covered
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	Not Covered
D3430	retrograde filling - per root	$90	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80	$80
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not Covered	$145
D3450	root amputation - per root	Not Covered	$110
D3471	Surgical repair of root resorption - anterior	$160	$160
D3472	Surgical repair of root resorption - premolar	$160	$160
D3473	Surgical repair of root resorption - molar	$160	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	$50
D3920	Hemisection (including any root removal; not including root canal therapy)	Not Covered	$120
D3950	Canal preparation and fitting of preformed dowel or post	Not Covered	$60
D3999	Unspecified endodontic procedure, by report	$100	$100
Periodontics			
D4210	gingivectomy or gingivoplasty - – four or more contiguous teeth or tooth bounded spaces per quadrant	$150	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50
D4240	Gingival flap procedure including root planing four or more teeth per quadrant	Not Covered	$135
D4241	Gingival flap procedure including root planing one to three teeth per quadrant	Not Covered	$70
D4249	Clinical crown lengthening – hard tissue	$165	$200
D4260	Osseous – muco - gingival surgery per quadrant	$265	$265
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	$140	$140
D4263	Bone replacement graft - first site in quadrant	Not Covered	$105
D4264	Bone replacement graft - each additional site in quadrant	Not Covered	$75
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site.	$80	$80
D4266	Guided tissue regeneration, natural teeth - resorbable barrier - per site	Not Covered	$145
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier - per site	Not Covered	$175
D4270	Pedicle soft tissue graft procedure	Not Covered	$155
D4273	Subepithelial connective tissue graft procedure - per tooth	Not Covered	$220
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	Not Covered	$190

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D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$185
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$175
D4286	Removal of non-resorbable barrier	Not Covered	$175
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$55	$55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$30	$25
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$40	$40
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	$10
D4910	Periodontal maintenance	$30	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15	Not Covered
D4999	Unspecified periodontal procedure, by report	$350	$350
Prosthodontics, Removable			
D5110	complete denture - maxillary	$300	$400
D5120	complete denture - mandibular	$300	$400
D5130	immediate denture - maxillary	$300	$400
D5140	immediate denture - mandibular	$300	$400
D5211	maxillary partial denture - resin based (including retentive/clasping materials, rests, and teeth)	$300	$325
D5212	mandibular partial denture - resin based (including retentive/clasping materials, rests, and teeth)	$300	$325
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335	$375
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275	$300
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275	$300
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330	$370
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330	$370
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375

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D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Not Covered	$250
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	Not Covered	$250
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant	Not Covered	$250
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant	Not Covered	$250
D5410	adjust complete denture - maxillary	$20	$20
D5411	adjust complete denture – mandibular	$20	$20
D5421	adjust partial denture – maxillary	$20	$20
D5422	adjust partial denture – mandibular	$20	$20
D5511	repair broken complete denture base-mandibular	$40	$30
D5512	repair broken complete denture base-maxillary	$40	$30
D5520	replace missing or broken teeth - complete denture (each tooth)	$40	$30
D5611	repair resin denture base-mandibular	$40	$30
D5612	repair resin denture base-maxillary	$40	$30
D5621	repair cast framework-mandibular	$40	$35
D5622	repair cast framework-maxillary	$40	$35
D5630	repair or replace broken clasp	$50	$30
D5640	replace broken teeth - per tooth	$35	$30
D5650	add tooth to existing partial denture	$35	$35
D5660	add clasp to existing partial denture	$60	$45
D5670	Replace all teeth and acrylic on cast framework - maxillary	Not Covered	$195
D5671	Replace all teeth and acrylic on cast framework - mandibular	Not Covered	$195
D5710	Rebase complete maxillary denture	Not Covered	$155
D5711	Rebase complete mandibular denture	Not Covered	$155
D5720	Rebase maxillary partial denture	Not Covered	$150
D5721	Rebase mandibular partial denture	Not Covered	$150
D5730	reline complete maxillary denture (chairside)	$60	$80
D5731	reline complete mandibular denture (chairside)	$60	$80
D5740	reline maxillary partial denture (chairside)	$60	$75
D5741	reline mandibular partial denture (chairside)	$60	$75
D5750	reline complete maxillary denture (laboratory)	$90	$120
D5751	reline complete mandibular denture (laboratory)	$90	$120
D5760	reline maxillary partial denture (laboratory)	$80	$110
D5761	reline mandibular partial denture (laboratory)	$80	$110
D5850	tissue conditioning, maxillary	$30	$35
D5851	tissue conditioning, mandibular	$30	$35
D5862	Precision attachment, by report	$90	$100
D5863	Overdenture – Complete Maxillary	$300	$300
D5864	Overdenture – partial maxillary	$300	$300
D5865	Overdenture – Complete Mandibular	$300	$300
D5866	Overdenture – partial mandibular	$300	$300
D5876	Add metal substructure to acrylic full denture (per arch)	Not Covered	$30
D5899	Unspecified removable prosthodontic procedure, by report	$350	$400
Maxillofacial Prosthetics			

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D5911	Facial moulage (sectional)	$285	Not Covered
D5912	Facial moulage (complete)	$350	Not Covered
D5913	Nasal prosthesis	$350	Not Covered
D5914	Auricular prosthesis	$350	Not Covered
D5915	Orbital prosthesis	$350	Not Covered
D5916	Ocular prosthesis	$350	Not Covered
D5919	Facial prosthesis	$350	Not Covered
D5922	Nasal septal prosthesis	$350	Not Covered
D5923	Ocular prosthesis, interim	$350	Not Covered
D5924	Cranial prosthesis	$350	Not Covered
D5925	Facial augmentation implant prosthesis	$200	Not Covered
D5926	Nasal prosthesis, replacement	$200	Not Covered
D5927	Auricular prosthesis, replacement	$200	Not Covered
D5928	Orbital prosthesis, replacement	$200	Not Covered
D5929	Facial prosthesis, replacement	$200	Not Covered
D5931	Obturator prosthesis, surgical	$350	Not Covered
D5932	Obturator prosthesis, definitive	$350	Not Covered
D5933	Obturator prosthesis, modification	$150	Not Covered
D5934	Mandibular resection prosthesis with guide flange	$350	Not Covered
D5935	Mandibular resection prosthesis without guide flange	$350	Not Covered
D5936	Obturator prosthesis, interim	$350	Not Covered
D5937	Trismus appliance (not for TMD treatment)	$85	Not Covered
D5951	Feeding aid	$135	Not Covered
D5952	Speech aid prosthesis, pediatric	$350	Not Covered
D5953	Speech aid prosthesis, adult	$350	Not Covered
D5954	Palatal augmentation prosthesis	$135	Not Covered
D5955	Palatal lift prosthesis, definitive	$350	Not Covered
D5958	Palatal lift prosthesis, interim	$350	Not Covered
D5959	Palatal lift prosthesis, modification	$145	Not Covered
D5960	Speech aid prosthesis, modification	$145	Not Covered
D5982	Surgical stent	$70	Not Covered
D5983	Radiation carrier	$55	Not Covered
D5984	Radiation shield	$85	Not Covered
D5985	Radiation cone locator	$135	Not Covered
D5986	Fluoride gel carrier	$35	Not Covered
D5987	Commissure splint	$85	Not Covered
D5988	Surgical splint	$95	Not Covered
D5991	Topical Medicament Carrier	$70	Not Covered
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not Covered
Implant Services			
D6010	Surgical placement of implant body: endosteal implant	$350	Not Covered
D6011	Surgical access to an implant body (second stage implant surgery)	$350	Not Covered
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350	Not Covered
D6013	Surgical placement of mini implant	$350	Not Covered
D6040	Surgical placement: eposteal implant	$350	Not Covered

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D6050	Surgical placement: transosteal implant	$350	Not Covered
D6055	Connecting bar - implant supported or abutment supported	$350	Not Covered
D6056	Prefabricated abutment - includes modification and placement	$135	Not Covered
D6057	Custom fabricated abutment - includes placement	$180	Not Covered
D6058	Abutment supported porcelain/ceramic crown	$320	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	$315	Not Covered
D6065	Implant supported porcelain/ceramic crown	$340	Not Covered
D6066	Implant supported crown (porcelain fused to high noble alloys)	$335	Not Covered
D6067	Implant supported crown (high noble alloys)	$340	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not Covered
D6075	Implant supported retainer for ceramic FPD	$335	Not Covered
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330	Not Covered
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350	Not Covered
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30	Not Covered
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	Not Covered
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	Not Covered
D6083	Implant supported crown - porcelain fused to noble alloys	$335	Not Covered
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	Not Covered
D6085	Interim implant crown	$300	Not Covered
D6086	Implant supported crown - predominantly base alloys	$340	Not Covered
D6087	Implant supported crown - noble alloys	$340	Not Covered
D6088	Implant supported crown - titanium and titanium alloys	$340	Not Covered
D6090	Repair implant supported prosthesis, by report	$65	Not Covered
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40	Not Covered

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D6092	Recement implant/abutment supported crown	$25	Not Covered
D6093	Recement implant/abutment supported fixed partial denture	$35	Not Covered
D6094	Abutment supported crown (titanium)	$295	Not Covered
D6095	Repair implant abutment, by report	$65	Not Covered
D6096	Remove broken implant retaining screw	$60	Not Covered
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	Not Covered
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	Not Covered
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	Not Covered
D6100	Surgical removal of implant body	$110	Not Covered
D6105	Removal of implant body not requiring bone removal or flap elevation	$110	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	Not Covered
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	Not Covered
D6119	Implant/abutment supported interim fixed denture for edentulous arch -maxillary	$350	Not Covered
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330	Not Covered
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350	Not Covered
D6122	Implant supported retainer for metal FPD – noble alloys	$350	Not Covered
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350	Not Covered
D6190	Radiographic/Surgical implant index, by report	$75	Not Covered
D6191	Semi-precision abutment – placement	$350	Not Covered
D6192	Semi-precision attachment – placement	$350	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium and titanium alloys	$265	Not Covered
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	Not Covered
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	Not Covered
D6198	Remove interim implant component	$110	Not Covered
D6199	Unspecified implant procedure, by report	$350	Not Covered

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Prosthodontics, fixed			
D6205	Pontic - indirect resin based composite	Not Covered	$165
D6210	pontic - cast high noble metal	Not Covered	$300
D6211	pontic - cast predominantly base metal	$300	$300
D6212	pontic - cast noble metal	Not Covered	$300
D6214	Pontic - cast titanium and titanium alloys	Not Covered	$300
D6240	pontic - porcelain fused to high noble metal	Not Covered	$300
D6241	pontic - porcelain fused to predominantly base metal	$300	$300
D6242	pontic - porcelain fused to noble metal	Not Covered	$300
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not Covered	$300
D6245	Pontic - porcelain/ceramic	$300	$300
D6250	Pontic - resin with high noble metal	Not Covered	$300
D6251	pontic - resin with predominantly base metal	$300	$300
D6252	Pontic - resin with noble metal	Not Covered	$300
D6545	retainer - cast metal for resin bonded fixed prosthesis	Not Covered	$130
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	$145
D6549	Retainer – for resin bonded fixed prosthesis	Not Covered	$130
D6608	Onlay - porcelain/ceramic - two surfaces	Not Covered	$200
D6609	Onlay - porcelain/ceramic - three or more surfaces	Not Covered	$200
D6610	Onlay - cast high noble metal - two surfaces	Not Covered	$200
D6611	Onlay - cast high noble metal - three or more surfaces	Not Covered	$200
D6612	Onlay - cast predominantly base metal - two surfaces	Not Covered	$200
D6613	Onlay - cast predominantly base metal - three or more surfaces	Not Covered	$200
D6614	Onlay - cast noble metal- two surfaces	Not Covered	$200
D6615	Onlay - cast noble metal - three or more surfaces	Not Covered	$200
D6634	Onlay - titanium	Not Covered	$200
D6710	Crown - indirect resin based composite	Not Covered	$200
D6720	crown - resin with high noble metal	Not Covered	$300
D6721	crown - resin with predominantly base metal	$300	$300
D6722	crown - resin with noble metal	Not Covered	$300
D6740	crown - porcelain/ceramic	$300	$300
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	$300
D6751	crown - porcelain fused to predominantly base metal	$300	$300
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	$300
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	$300
D6781	crown - 3/4 cast predominantly base metal	$300	$300
D6782	crown - 3/4 cast noble metal	Not Covered	$300
D6783	crown - 3/4 porcelain/ceramic	$300	$300
D6784	Retainer crown ¾ - titanium and titanium alloys	$300	$300
D6791	crown - full cast predominantly base metal	$300	$300
D6794	Retainer crown - titanium and titanium alloys	Not Covered	$300
D6930	Recement bridge	$40	$40
D6980	fixed partial denture repair necessitated by restorative material failure	$95	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350	$400
Oral Maxillofacial Surgery			
D7111	Extraction, coronal remnants - primary tooth	$40	$40
D7140	extraction, erupted tooth or exposed root	$65	$65

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D7210	surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	$120	$115
D7220	removal of impacted tooth - soft tissue	$95	$85
D7230	removal of impacted tooth - partially bony	$145	$145
D7240	removal of impacted tooth - completely bony	$160	$160
D7241	Removal of impacted tooth - complete bony with unusual surgical complications	$175	$175
D7250	surgical removal of residual tooth roots requiring cutting of soft tissue and bone and	$80	$75
D7260	Oral Antral Fistula Closure	$280	$280
D7261	Primary closure of a sinus perforation	$285	$285
D7270	tooth reimplantation / stabilization	$185	$185
D7280	Surgical access of an unerupted tooth	$220	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85	$85
D7285	biopsy of oral tissue - hard (bone, tooth)	$180	$180
D7286	biopsy of oral tissue - soft	$110	$110
D7287	Exfoliative cytological sample collection	Not Covered	$35
D7288	Brush biopsy transepithelial sample collection	Not Covered	$35
D7290	Surgical repositioning of teeth	$185	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	$80
D7310	alveoloplasty in conjunction with extractions – per quadrant	$85	$85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per	$50	$50
D7320	alveoloplasty not in conjunction with extractions – per quadrant	$120	$120
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	$350
D7410	excision of benign lesion up to 1.25 cm	$75	$75
D7411	excision of benign lesion greater than 1.25 cm	$115	$115
D7412	Excision of benign lesion, complicated	$175	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120	$120
D7415	Excision of malignant lesion, complicated	$255	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185	$200
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	$180
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	$330
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	$180
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	$50
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140
D7472	Removal of Torus Palatinus	$145	$140

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D7473	Removal of torus mandibularis	$140	$140
D7485	Surgical reduction of osseous tuberosity	$105	$105
D7490	Radical resection of maxilla or mandible	$350	$350
D7509	Marsupialization of odontogenic cyst	$180	$180
D7510	incision and drainage of abscess - intraoral soft tissue	$70	$55
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	$70	$69
D7520	incision and drainage of abscess - extraoral soft tissue	$70	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350	$580
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350	$480
D7650	Malar and/or zygomatic arch – open reduction	$350	$270
D7660	Malar and/or zygomatic arch – closed reduction	$350	$580
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	$500
D7710	Maxilla – open reduction	$110	$110
D7720	Maxilla – closed reduction	$180	$180
D7730	Mandible – open reduction	$350	$390
D7740	Mandible – closed reduction	$290	$290
D7750	Malar and/or zygomatic arch – open reduction	$220	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350	$1,100
D7770	Alveolus – open reduction stabilization of teeth	$135	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	$440
D7810	Open reduction of dislocation	$350	$730
D7820	Closed reduction of dislocation	$80	$80
D7830	Manipulation under anesthesia	$85	$85
D7840	Condylectomy	$350	$930
D7850	Surgical discectomy, with/without implant	$350	$900
D7852	Disc repair	$350	$400
D7854	Synovectomy	$350	$390
D7856	Myotomy	$350	$600
D7858	Joint reconstruction	$350	$860
D7860	Arthrostomy	$350	$350
D7865	Arthroplasty	$350	$510
D7870	Arthrocentesis	$90	$90
D7871	Non-arthroscopic lysis and lavage	$150	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350	$350

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D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350	$1,200
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350	$410
D7875	Arthroscopy – surgical: synovectomy	$350	$410
D7876	Arthroscopy – surgical: discectomy	$350	$270
D7877	Arthroscopy – surgical: debridement	$350	$430
D7880	Occlusal orthotic device, by report	$120	$120
D7881	Occlusal orthotic device adjustment	$30	$50
D7899	Unspecified TMD therapy, by report	$350	$350
D7910	Suture of recent small wounds up to 5 cm	$35	$50
D7911	Complicated suture – up to 5 cm	$55	$75
D7912	Complicated suture – greater than 5 cm	$130	$150
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not Covered
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	$80
D7940	Osteoplasty – for orthognathic deformities	$160	Not Covered
D7941	Osteotomy – mandibular rami	$350	Not Covered
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350	Not Covered
D7944	Osteotomy – segmented or subapical	$275	Not Covered
D7945	Osteotomy – body of mandible	$350	Not Covered
D7946	LeFort I (maxilla – total)	$350	Not Covered
D7947	LeFort I (maxilla – segmented)	$350	Not Covered
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350	Not Covered
D7949	LeFort II or LeFort III – with bone graft	$350	Not Covered
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190	Not Covered
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not Covered
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175	Not Covered
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not Covered
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	Not Covered	$145
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	Not Covered	$175
D7961	Buccal / labial frenectomy (frenulectomy)	$120	$120
D7962	Lingual frenectomy (frenulectomy)	$120	$120
D7963	Frenuloplasty	$120	$120
D7970	Excision of hyperplastic tissue - per arch	$175	$176
D7971	Excision of pericoronal gingival	$80	$80
D7972	Surgical reduction of fibrous tuberosity	$100	Not Covered
D7979	Non-surgical Sialolithotomy	$155	$155
D7980	Surgical sialolithotomy	$155	$155
D7981	Excision of salivary gland, by report	$120	$120
D7982	Sialodochoplasty	$215	$215
D7983	Closure of salivary fistula	$140	$140
D7990	Emergency tracheotomy	$350	Not Covered
D7991	Coronoidectomy	$345	Not Covered

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D7995	Synthetic graft – mandible or facial bones, by report	$150	Not Covered
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not Covered
D7999	Unspecified oral surgery procedure, by report	$350	$350
Orthodontics			
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$350	Not Covered
D8210	Removable appliance therapy		
D8220	Fixed appliance therapy		
D8660	Pre-orthodontic treatment visit		
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance – maxillary		
D8697	Repair of orthodontic appliance – mandibular		
D8698	Re-cement or re-bond fixed retainer – maxillary		
D8699	Re-cement or re-bond fixed retainer – mandibular		
D8701	Repair of fixed retainer, includes reattachment – maxillary		
D8702	Repair of fixed retainer, includes reattachment – mandibular		
D8703	Replacement of lost or broken retainer – maxillary		
D8704	Replacement of lost or broken retainer – mandibular		
D8999	Unspecified orthodontic procedure, by report		
Adjunctive General Services			
D9110	palliative treatment of dental pain - per visit	$30	$28
D9120	Fixed partial denture sectioning	$95	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10	$10
D9211	Regional block anesthesia	$20	$20
D9212	Trigeminal division block anesthesia	$60	$60
D9215	local anesthesia	$15	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45	$45
D9222	Deep sedation/general anesthesia - first 15 minute	$45	$45
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	$45
D9230	analgesia nitrous oxide	$15	Not Covered
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	$45
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	$45
D9248	non-intravenous conscious sedation	$65	Not Covered
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	$45
D9311	Consultation with a medical health professional	No Charge	No Charge
D9410	House/Extended care facility call	$50	Not Covered
D9420	Hospital or ambulatory surgical center call	$135	Not Covered
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$20	$12
D9440	office visit - after regularly scheduled hours	$45	$40

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D9450	Case presentation, subsequent to detailed and extensive treatment	Not Covered	No Charge
D9610	Therapeutic parenteral drug, single administration	$30	Not Covered
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40	Not Covered
D9910	Application of desensitizing medicament	$20	$22
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35	$50
D9942	Repair and/or reline of occlusal guard	Not Covered	$35
D9943	Occlusal guard adjustment	Not Covered	$35
D9944	Occlusal guard hard appliance, full arch	Not Covered	$115
D9945	Occlusal guard soft appliance, full arch	Not Covered	$115
D9946	Occlusal guard hard appliance, partial arch	Not Covered	$115
D9950	Occlusion analysis – mounted case	$120	Not Covered
D9951	Occlusal adjustment - limited	$45	$45
D9952	Occlusal adjustment - complete	$210	$210
D9995	Teledentistry - synchronous; real-time encounter	No Charge	No Charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Charge	No Charge
D9997	Dental case management - patients with special health care needs	No Charge	No Charge
D9999	unspecified adjunctive procedure, by report	No Charge	No Charge

Endnotes to 2024 Dental Standard Benefit Plan Designs

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

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
5) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
6) To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

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

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

health plan are not considered “comparable” dental coverage for purposes of counting towards the waiting period.

9) To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

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

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

EXCLUSIONS

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

LIMITATIONS

- Prophylaxis (teeth cleaning) is limited to once every six months.
- Fluoride treatment is covered once every 6 months.
- Bitewing x-rays are limited to one series of four films every 12 months.

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

OUT-OF-POCKET MAXIMUM (OOPM)

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. Refer to the 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.

- **Children up to age 19 only - Individual Child $350**
- **Children up to age 19 only – Two or more children in a family $700**

UTILIZATION INFORMATION

PATIENT ENCOUNTER DATA

California Dental Network, Inc. requires submission of patient encounter data only for those covered procedures that you render to California Dental Network members. Submission of patient encounter information is required for all patients under the Covered California Plans.

Encounter data should be submitted to California Dental Network monthly via the following formats:

- Universal Claim Form.*
- Computer printout with data equivalent to Claim Form information.

*Please indicate clearly that the form is encounter data so that it will not be processed as a claim.

CLAIM SUBMISSION

Claims should be submitted promptly to the Plan to ensure timely payment, and allow the Plan to track patient utilization and out-of-pocket expenses. Assure that the information submitted meets the requirements for listed in the Limitations and Exclusions for the member.

Paper Claims should be sent to:
CALIFORNIA DENTAL NETWORK- Claims
23291 Mill Creek Dr. Ste 100
Laguna Hills, CA 92653
Fax: 657-235-0145

ADDENDUM FOR 2024
PEDIATRIC DENTAL SERVICES

To be provided by California Dental Network, Inc.

200 Oceangate, Suite 100
Long Beach, CA 90802

DEFINITIONS

"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 that includes severe pain or bleeding associated with dental problems, and/or unforeseen dental conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction or death 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.

"Exclusion" means any service that is listed as not covered by CDN or the Provider.

"Limitation" means any service other than an Exclusion that restricts Coverage under this plan.

"Dental Provider" refers to those dentists, who have contracted with CDN, and includes any hygienists or assistants that act under the supervision of the dentist, to provide services to Members.

"Dental Specialist" means a dentist who is responsible for the dental care of a Member in one field of dentistry, such as endodontics, periodontics, pedodontics, oral surgery or orthodontics.

"Annual Out-of-Pocket Maximum" (also referred to as "OOPM"): means the most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on deductibles, copayments, and coinsurance, CDN pays 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members. Amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards the OOPM. The Schedule of Benefits may list an OOPM amount for each individual enrolled and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement: 1) the individual OOPM will be met, with respect to the Subscriber or a Dependent, when that person meets the individual OOPM amount; or 2) the family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount. Once the total Cost Sharing for the Subscriber or a Dependent adds up to the individual OOPM amount, CDN will pay 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members for the rest of the plan year for the pediatric enrollee. Once the cost sharing for two or more Member's family adds up to the family OOPM amount, CDN will pay 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members for the rest of the plan year for the Member and every pediatric (children up to age 19) Member of their family.

"Participating Dental Provider" means a dentist who has a contract with CDN to treat our insured members.

"Pediatric Essential Health Benefits" are one of the ten Essential Health Benefits required under

the Affordable Care Act (ACA). Pediatric essential health benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

"Primary Dentist" means the main dentist who the member has elected or has been assigned to for their dental treatment and is a participating dental provider.

"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.

HOW DO I USE MY BENEFITS?

In addition to your Molina Healthcare of California EOC you will receive a letter from California Dental Network (CDN) with the telephone number and address of Your dental office.

A complete list of covered services and copayments is included at the end of this Addendum. Services excluded from Your Coverage are found in the section titled Benefits, Exclusions and Limitations. Please read this section carefully. Dental services by an out-of-network dentist or specialist are not covered. Under certain emergency situations services by a non-participating general dentist may be covered.

HOW DO I CHANGE MY DENTAL PROVIDER?

THE FOLLOWING INFORMATION TELLS YOU THE GROUPS OF PROVIDERS WHO CAN PROVIDE YOU WITH DENTAL CARE.

You may select any CDN Participating Dental Provider for Your dental care. You can change Your Primary Dentist at any time. Please contact Dental Customer Support toll-free at 1-855-424-8106 to change your Primary Dentist. Any request received by the 20th of the month is effective on the first day of the month following. Any request received after the 20th of the month is effective on the first day of the following calendar month. We may require up to 30 days to process a request.

DENTAL PROVIDERS

CDN's participating dental offices are open during normal business hours and some offices are open on Saturday. Check your provider directory for more information on provider office hours and languages spoken at participating offices. If You are having difficulty locating a Participating Dental Provider in your area within the access standards of the plan, contact Dental Customer Support at 1-855-424-8106 to receive authorization for out of network services. You will be able to select a provider of your choice in the immediate area. Authorization will be given for exam and x-rays, all treatment must be submitted for approval.

How do I get Emergency Services?

Emergency and urgent dental care is covered 24 hours a day, seven days a week, for all Members. Emergency dental Care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is care required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefits is the relief of acute symptoms only (for example: severe pain or bleeding) and does not include completed restoration. Please contact your Participating Dentist for emergency or urgent dental care. If your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-855-424-8106.

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 or urgent 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.

What do I do if I am out of the area?

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

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

Emergency dental care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is treatment required within 24 to 72 hours, and are

services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for emergency or urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding, or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefit is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration.

To see a Specialist

If Your Primary Dentist decides that You need the services of a specialist, they will request Prior Authorization for a referral to a CDN Specialist. CDN will send You a letter of treatment authorization, including the name, address, and phone number of Your assigned CDN specialist. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by CDN to make the determination. If an emergency referral is required, Your Primary Dentist will contact CDN and prompt arrangements will be made for specialty treatment. Emergency referrals are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by CDN to make the determination. Your Primary Dentist will be informed of CDN's decision within 24 hours of the determination. Both the general provider and the patient will be notified in writing of approval or denial.

If You have questions about how a certain service is approved, call CDN toll-free at [1-855-424-8106]. 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 from CDN, you will be responsible for the specialist's fee for any services rendered.

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.

COMPLAINTS AND APPEALS

All dental complaints and appeals will be handled according to Molina's complaints and appeals process as outlined in this EOC.

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 the primary dental benefit payer is a health plan purchased through Covered California which includes pediatric dental essential health benefits. Any standalone dental plan offering the pediatric dental essential health benefit whether as a separate benefit or combined with a family dental benefit, covers benefits as a secondary dental benefit plan payer. The primary dental benefit payer is this health plan purchased through Covered California and includes pediatric dental essential health 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.

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.

<u>General Practice Second Opinion</u>
A request for a second opinion may be processed if one or more of the following conditions are evident:

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

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to a CDN Dental Director for consideration.
Members may obtain a second opinion by contacting CDN at 1-855-424-8106. 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.

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.

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.

TIMELY ACCESS TO CARE & INTERPRETER SERVICES

CDN is required to provide or arrange for the provision of covered dental care services in a timely manner appropriate for the nature of the enrollee's condition, consistent with good professional practice. CDN ensures that enrollees are able to access clinically appropriate care in a timely manner. Urgent appointments within the CDN contracted provider network are available within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice. Non-urgent (routine) appointments are available within 36 business days of the request for appointment. Preventive dental care appointments are available within 40 business days of the request for appointment.
Interpretation services are available to members at all points of contact, including when a member is accompanied by a family member or friend who can provide interpretation services, at no cost to the member. To arrange for interpreter services at your dental appointment or other point of contact please contact the CDN member services department.

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 subscribers and enrollees may request confidential communication by direct mail or through electronic communication. Mail requests to:

California Dental Network, Inc
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
or Phone:
(949) 830-1600: Toll-Free (877) 425-4164

CDN will implement confidential communications requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail.

CDN does not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.

CDN does not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.

CDN permits and accommodates requests for confidential communications in the form and format requested by the protected individual, if readily producible in the requested form and format, or at alternative locations.

The confidential request will be valid until the subscriber or enrollee submits a revocation of request or a new confidential communication request is submitted. The confidential communication request will apply to all communications that disclose medical information or provider name and address related to the receipt of medical services by the individual requesting the confidential communication.

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.

TELEDENTISTRY

This plan includes coverage for dental services appropriately delivered through teledentistry services. In general, teledentistry can be used to make basic diagnoses, triage emergencies, and answer oral care questions. During a virtual visit, your dentist might determine that you need to be seen now for emergency care or decide you can wait until after regular in-office appointments resume. Services are covered on the same basis and to the same extent that the same service through in-person diagnosis, consultation, or treatment is covered. Coverage is not limited only to services delivered by select third-party corporate telehealth providers.

BENEFITS, EXCLUSIONS, AND LIMITATIONS

Pediatric Dental Essential Health 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 Provider 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.

CDN monitors out-of-pocket payments over the course of the plan year. CDN will provide the pediatric enrollee with their balance accrued toward their annual deductible and annual OOPM for every month in which benefits were used and until the annual balance equals the full OOPM amount. Pediatric enrollees may request their most up-to-date accrual balance toward their

annual OOPM from us at any time. 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.

Accrual updates shall be mailed to enrollees unless the enrollee has elected to opt out of mailed notice and elected to receive the accrual update electronically, or unless the enrollee has previously opted out of mailed notices.

- Enrollees who have opted out of receiving mailed notice may opt back in at any time.
- Accrual updates may be included with evidence of benefit statements.

CDN subscribers and enrollees may request confidential communication by direct mail or through electronic communication. Mail requests to:
California Dental Network, Inc
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653

or Phone:
(949) 830-1600: Toll-Free (877) 425-4164

Pediatric Dental Essential Health Benefits apply to members up to the age of 19. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable. [Minimum coverage plan benefits are covered at 100% by the plan after the member meets the deductible and Annual Out-of-Pocket Maximum. Please refer to page 17 for information on Annual Out-of-Pocket Maximum.] Members should keep receipts for all dental work to show out-of-pocket costs.

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, Comprehensive series (including bitewings) (D0210): once per provider every 36 months.
- Radiographs (X-rays), Intraoral, periapical first film (D0220): a benefit to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).

- Radiographs (X-rays), Intraoral, periapical each additional film (D0230): a benefit to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, occlusal film (D0240): A benefit up to a maximum of two in a six-month period per provider.
- Radiographs (X-rays), Extraoral (D0250): A benefit once per date of service.
- Radiographs (X-rays), bitewing , single film (D0270): A benefit once per date of service.
- Radiographs (X-rays), bitewings, two films (D0272): A benefit once every six months per provider.
- Radiographs (X-rays), bitewings, four films (D0274): A benefit once every six months per provider.
- Radiographs (X-rays) Temporomandibular joint arthrogram, including injection (D0320): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.
- Radiographs (X-rays) Tomographic survey (D0322): A benefit twice in a 12 month period per provider.
- Radiographs (X-rays) Panoramic film (D0330): A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
- Radiographs (X-rays), Cephalometric radiographic image (D0340): A benefit twice in a 12 month period per provider.
- 2D oral/facial photographic image obtained intra-orally or extra-orally (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). 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). 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, maxillary (D1516): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral, mandibular (D1517): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. Space maintainer, removable, unilateral (D1520): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires
- Space maintainer, removable, bilateral, maxillary (D1526): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, removable, bilateral, mandibular (D1527): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Re-cement or re-bond bilateral space maintainer-maxillary (D1551): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.
- Re-cement or re-bond bilateral space maintainer-mandibular (D1552): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.

- Re-cement or re-bond unilateral space maintainer-per quadrant (D1553): 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, 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 – permanent tooth (D2928): 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.
- 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, premolar 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-premolar (D3347).
- Root canal therapy, molar tooth (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), premolar (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 - premolar (first root) (D3421): A benefit for permanent premolar 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 (including retentive/clasping materials, 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 premolar are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Partial denture - cast metal resin based (including retentive/clasping materials any 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 premolar are missing on the same side. Not a benefit for replacing missing 3rd molars.

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

- Repair or replace broken clasp (D5630): A benefit up to a maximum of three, per date of service per provider; twice per arch, in a 12- month period per provider.
- Replace broken teeth - per tooth (D5640): A benefit: up to a maximum of four, per arch, per date of service per provider; twice per arch, in a 12- month period per provider; for partial dentures only.
- Add tooth to existing partial denture (D5650): A benefit: for up to a maximum of three, per date of service per provider; once per tooth. Not a benefit for adding 3rd molars.
- Add clasp to existing partial denture (D5660): A benefit: for up to a maximum of three, per date of service per provider; twice per arch, in a 12-month period per provider.
- Reline complete denture (chairside) upper (D5730): a benefit once in a 12-month period; six months after the date of service for an immediate denture- maxillary (D5130)) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
- Reline complete denture (chairside) lower (D5731): Each a benefit once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
- Reline partial denture (chairside) upper (D5740): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that required extractions, or 12 months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) maxillary (D5760).
- Reline partial denture (chairside) lower (D5741): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that required extractions, or 12 months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) mandibular (D5761).
- Reline complete denture (laboratory) upper (D5750): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) maxillary (D5730).
- Reline complete denture (laboratory) lower (D5751): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- mandibular (D5140)

or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) mandibular (D5731).

- Reline upper partial denture (laboratory) (D5760): A benefit: once in a 12-month period; six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions. Not a benefit within 12 months of a reline maxillary partial denture (chairside) (D5740); for a maxillary partial denture- resin base (D5211).
- Reline lower partial denture (laboratory) (D5761): A benefit once in a 12-month period; six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions. Not a benefit within 12 months of a reline mandibular partial denture (chairside) (D5741); for a mandibular partial denture- resin base (D5212).
- Tissue conditioning, upper (D5850): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); or same date of service as a prosthesis that did not require extractions.
- Tissue conditioning, lower (D5851): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761), or same date of service as a prosthesis that did not require extractions.
- Overdenture-axillary (D5863): A benefit once in a five- year period.
- Overdenture-mandibular (D5865): A benefit once in a five- year period.
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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 crown - porcelain fused to high noble alloys (D6066): See D6010
- Implant supported metal crown (high noble alloys) (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 FPD - porcelain fused to high noble alloys (D6076): See D6010
- Implant supported retainer for metal FPD high noble alloys (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Implant supported crown (porcelain fused to predominately base alloys (D6082): See D6010
- Implant supported crown (porcelain fused to noble alloys (D6083): See D6010

- Implant supported crown (porcelain fused to titanium and titanium alloys) (D6084): See D6010Implant supported crown (predominately base alloys (D6086): See D6010
- Implant supported crown (noble alloys (D6087): See D6010
- Implant supported crown (titanium and titanium alloys) (D6088): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of replaceable part of semi-precision or precision 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
- Abutment supported crown - porcelain fused to titanium and titanium alloys (6097): See D6010
- Implant supported retainer - porcelain fused to predominantly base alloys (D6098): See D6010
- Implant supported retainer for FPD - porcelain fused to noble alloys (6099): See D6010
- Implant supported retainer – porcelain fused to titanium and titanium alloys (6120): See D6010
- Implant supported retainer for metal FPD – predominantly base alloys (6121): See D6010
- Implant supported retainer for metal FPD – noble alloys (6122): See D6010
- Implant supported retainer for metal FPD – titanium and titanium alloys (6123): 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, D6784 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, D6784 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, D6784 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, D6784 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.
- Retainer crown ¾ - titanium and titanium alloys (D6784): 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 - primary 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.
- Buccal / labial frenectomy (frenulectomy) (D7961): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Lingual frenectomy (frenulectomy) (D7962): 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 maxillary (D8696): 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.
- Repair of orthodontic appliance mandibular (D8697): 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.
- Re-cement or re-bond fixed retainer – maxillary (D8698): A benefit for patients under the age of 21; once per provider.
- Re-cement or re-bond fixed retainer – mandibular (D8699): A benefit for patients under the age of 21; once per provider.
- Repair of fixed retainer, includes reattachment – maxillary (D8701): A benefit for patients under the age of 21; once per provider.
- Repair of fixed retainer, includes reattachment – mandibular (D8702): A benefit for patients under the age of 21; once per provider.
- Replacement of lost or broken retainer – maxillary (D8703) 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
- Replacement of lost or broken retainer – mandibular (D8704) A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention

Benefits and Limits for Adjunctive Services

- Palliative treatment of dental pain – per visit (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 (D9239 OR 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 (D9239 OR 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 15 minutes (D9239): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - each subsequent15 minute increment (D9239 OR 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 (D9239 OR 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 (D9239 OR 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.

DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records are confidential. This confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.

This 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 must be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to the request within 30 days after we receive it.

California Dental Network'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 provider who has custody of the records. If the provider denies Member the request to add an addendum, the Member should contact Dental Customer Support for assistance.

A STATEMENT OF OUR CONFIDENTIALITY POLICY IS AVAILABLE TO YOU UPON REQUEST.

GENERAL PROVISIONS

- CDN is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 as amended 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 Provider network to provide dental services to Group.

- In the event any of CDN's Providers should terminate their relationship with CDN, breach their Provider Agreement with CDN, or be unable to render dental services hereunder, and Members would be adversely or materially affected, CDN will give effected Members written notice thereof.

- Upon termination of a Provider Contract, CDN shall be responsible to ensure completion of the covered services rendered by such Provider (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 Provider at the time of such termination until the services being rendered to the Members by such Provider are completed, unless CDN makes reasonable and medically appropriate provisions for the assumption of such services by another Provider.

- 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.

INDEPENDENT MEDICAL REVIEW

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-855-424-8106) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a

grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online

Molina Healthcare of California / California Dental Network

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS		
	[Molina Minimum Coverage HMO] [Molina Bronze[60] HMO][Molina Silver[70] HMO][Molina Silver[94] HMO][Molina Silver[87] HMO][Molina Silver[73] HMO][Molina Gold[80] HMO][Molina Platinum[90] HMO]	

	Individual Child	**Family (2 or more children)**
Deductible	None	None
Office Copay	No Charge	No Charge
Waiting Period	None	None
Annual Benefit Limit	None	None

The following is a list of Covered Pediatric Dental Essential Health Benefits, along with your cost share, when performed by a CDN Participating Dental Provider and subject to the exclusions and limitations in this EOC:

Code	**Description**	**Member Copayment**
Diagnostic		
D0120	periodic oral evaluation	No Charge
D0140	limited oral evaluation	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	comprehensive oral evaluation	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation	No Charge
D0210	intraoral - Comprehensive series (including bitewings) - limited to 1 series every 36 months	No Charge
D0220	intraoral - periapical first film	No Charge
D0230	intraoral - periapical each additional film	No Charge
D0240	intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0251	Extra-oral posterior dental radiographic image	No Charge
D0270	bitewing - single film	No Charge
D0272	bitewings - two films	No Charge
D0273	Bitewings - three films	No Charge
D0274	bitewings - four films - limited to 1 series every 6 months	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge

D0322	Tomographic survey	No Charge
D0330	panoramic film	No Charge
D0340	Cephalometric radiographic image	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No Charge
D0460	pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge
D0701	Panoramic radiographic image – image capture only	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No Charge
D0706	Intraoral – occlusal radiographic image – image capture only	No Charge
D0707	Intraoral – periapical radiographic image – image capture only	No Charge
D0708	Intraoral – bitewing radiographic image – image capture only	No Charge
D0709	Intraoral – comprehensive series of radiographic images – image capture only	No Charge
D0801	**3D dental surface scan - direct**	**No Charge**
D0802	3D dental surface scan - indirect	No Charge
D0803	3D facial surface scan - direct	No Charge
D0804	3D facial surface scan - indirect	No Charge
D0999	**Unspecified diagnostic procedure, by report**	**No Charge**
Preventive		
D1110	Prophylaxis-Adult	No Charge
D1120	prophylaxis - child	No Charge
D1206	topical fluoride varnish	No Charge
D1208	topical application of fluoride	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No Charge
D1330	oral hygiene instructions	No Charge
D1351	sealant - per tooth	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1353	Sealant repair – per tooth	No Charge
D1354	Interim caries arresting medicament application – per tooth	No Charge
D1355	Caries preventive medicament application – per tooth	No Charge
D1510	space maintainer - fixed - unilateral	No Charge
D1516	space maintainer - fixed – bilateral, maxillary	No Charge
D1517	space maintainer - fixed – bilateral, mandibular	No Charge
D1520	Space maintainer-removable – unilateral	No Charge

D1526	space maintainer - removable – bilateral, maxillary	No Charge
D1527	space maintainer - removable – bilateral, mandibular	No Charge
D1551	Re-cement or re-bond bilateral space maintainer-maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer- mandibular	No Charge
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer-per quadrant	No Charge
D1557	Removal of fixed space maintainer-maxillary	No Charge
D1558	Removal of fixed space maintainer-mandibular	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral, per quadrant	No Charge
Restorative		
D2140	amalgam - one surface permanent or primary	$25
D2150	amalgam - two surfaces permanent or primary	$30
D2160	amalgam - three surfaces permanent or primary	$40
D2161	amalgam - four or more surfaces permanent or primary	$45
D2330	resin-based composite - one surface, anterior	$30
D2331	resin-based composite - two surfaces, anterior	$45
D2332	resin-based composite - three surfaces, anterior	$55
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60
D2390	Resin based composite crown, anterior	$50
D2391	Resin based composite - one surface, posterior	$30
D2392	Resin based composite - two surfaces, posterior	$40
D2393	Resin based composite - three surfaces, posterior	$50
D2394	Resin based composite - four or more surfaces, posterior	$70
D2710	crown - resin-based composite laboratory	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190
D2721	Crown - resin with predominantly base metal	$300
D2740	crown - porcelain/ceramic	$300
D2751	crown - porcelain fused to predominantly base metal	$300
D2781	crown - 3/4 cast predominantly base metal	$300
D2783	Crown – 3/4 porcelain/ceramic	$310
D2791	crown - full cast predominantly base metal	$300
D2910	Recement inlay, onlay or partial coverage restoration	$25
D2915	Recement cast or prefabricated post and core	$25
D2920	recement crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95
D2930	prefabricated stainless steel crown - primary tooth	$65
D2931	prefabricated stainless steel crown - permanent tooth	$75
D2932	Prefabricated resin crown	$75
D2933	Prefabricated stainless steel crown with resin window	$80
D2940	protective restoration	$25
D2941	Interim therapeutic restoration – primary dentition	$30

D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins	$20
D2951	pin retention - per tooth, in addition to restoration	$25
D2952	post and core in addition to crown, indirectly fabricated	$100
D2953	Each additional indirectly fabricated post, same tooth	$30
D2954	prefabricated post and core in addition to crown	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35
D2980	crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap (indirect) excluding final restoration	$25
D3220	therapeutic pulpotomy (excluding final restoration)	$40
D3221	Pulpal debridement, primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55
D3310	root canal therapy, anterior tooth (excluding final restoration)	$195
D3320	root canal therapy, premolar tooth (excluding final restoration)	$235
D3330	root canal therapy, molar tooth (excluding final restoration)	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	retreatment of previous root canal therapy - anterior	$240
D3347	retreatment of previous root canal therapy - premolar	$295
D3348	retreatment of previous root canal therapy - molar	$350
D3351	apexification/recalcification – initial visit	$85
D3352	apexification/recalcification - interim	$45
D3410	apicoectomy/periradicular surgery - anterior	$240
D3421	apicoectomy/periradicular surgery - premolar (first root)	$250
D3425	apicoectomy/periradicular surgery - molar (first root)	$275
D3426	Apioectomy / periradicular surgery - molar, each additional root	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350
D3430	retrograde filling - per root	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80
D3471	Surgical repair of root resorption - anterior	$160
D3472	Surgical repair of root resorption - premolar	$160
D3473	Surgical repair of root resorption - molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30

D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – muco - gingival surgery per quadrant	$265
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site.	$80
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$40
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, Removable		
D5110	complete denture – maxillary	$300
D5120	complete denture – mandibular	$300
D5130	immediate denture - maxillary	$300
D5140	immediate denture - mandibular	$300
D5211	maxillary partial denture - resin based (including retentive/clasping materials, rests, and teeth)	$300
D5212	mandibular partial denture - resin based (including retentive/clasping materials, rests, and teeth)	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5410	adjust complete denture - maxillary	$20
D5411	adjust complete denture – mandibular	$20
D5421	adjust partial denture – maxillary	$20
D5422	adjust partial denture – mandibular	$20
D5511	repair broken complete denture base-mandibular	$40
D5512	repair broken complete denture base-maxillary	$40

D5520	replace missing or broken teeth - complete denture (each tooth)	$40
D5611	repair resin denture base-mandibular	$40
D5612	repair resin denture base-maxillary	$40
D5621	repair cast framework-mandibular	$40
D5622	repair cast framework--maxillary	$40
D5630	repair or replace broken clasp	$50
D5640	replace broken teeth - per tooth	$35
D5650	add tooth to existing partial denture	$35
D5660	add clasp to existing partial denture	$60
D5730	reline complete maxillary denture (chairside)	$60
D5731	reline complete mandibular denture (chairside)	$60
D5740	reline maxillary partial denture (chairside)	$60
D5741	reline mandibular partial denture (chairside)	$60
D5750	reline complete maxillary denture (laboratory)	$90
D5751	reline complete mandibular denture (laboratory)	$90
D5760	reline maxillary partial denture (laboratory)	$80
D5761	reline mandibular partial denture (laboratory)	$80
D5850	tissue conditioning, maxillary	$30
D5851	tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture-complete maxillary	$300
D5864	Overdenture-partial maxillary	$300
D5865	Overdenture-complete mandibular	$300
D5866	Overdenture-partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350

D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification	$145
D5960	Speech aid prosthesis, modification	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Topical Medicament Carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Surgical access to an implant body (second stage implant surgery)	$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340

D6066	Implant supported crown - porcelain fused to high noble alloys	$335
D6067	Implant supported crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown - porcelain fused to noble alloys	$335
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335
D6085	Interim implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown - noble alloys	$340
D6088	Implant supported crown - titanium and titanium alloys	$340
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6096	Remove broken implant retaining screw	$60
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6105	Removal of implant body not requiring bone removal or flap elevation	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350

D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch -maxillary	$350
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD – noble alloys	$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95
D6198	Remove interim implant component	$110
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, Fixed		
D6211	pontic - cast predominantly base metal	$300
D6241	pontic - porcelain fused to predominantly base metal	$300
D6245	Pontic - porcelain/ceramic	$300
D6251	pontic - resin with predominantly base metal	$300
D6721	crown - resin with predominantly base metal	$300
D6740	crown - porcelain/ceramic	$300
D6751	crown - porcelain fused to predominantly base metal	$300
D6781	crown - 3/4 cast predominantly base metal	$300
D6783	crown - 3/4 porcelain/ceramic	$300
D6784	Retainer crown ¾ - titanium and titanium alloys	$300
D6791	crown - full cast predominantly base metal	$300
D6930	recement bridge	$40
D6980	fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral Maxillofacial Surgery		
D7111	Extraction, coronal remnants - primary tooth	$40
D7140	extraction, erupted tooth or exposed root	$65
D7210	surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	$120
D7220	removal of impacted tooth - soft tissue	$95
D7230	removal of impacted tooth - partially bony	$145
D7240	removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - complete bony with unusual surgical complications	$175
D7250	surgical removal of residual tooth roots requiring cutting of soft tissue and bone and removal of tooth structure and closure.	$80

D7260	Oral Antral Fistula Closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	tooth reimplantation / stabilization	$185
D7280	Surgical access of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	biopsy of oral tissue - hard (bone, tooth)	$180
D7286	biopsy of oral tissue – soft	$110
D7290	Surgical repositioning of teeth	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80
D7310	alveoloplasty in conjunction with extractions – per quadrant	$85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50
D7320	alveoloplasty not in conjunction with extractions – per quadrant	$120
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350
D7410	excision of benign lesion up to 1.25 cm	$75
D7411	excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible)	$140
D7472	Removal of Torus Palatinus	$145
D7473	Removal of torus mandibularis	$140
D7485	Surgical reduction of osseous tuberosity	$105
D7490	Radical resection of maxilla or mandible	$350
D7509	Marsupialization of odontogenic cyst	$180
D7510	incision and drainage of abscess - intraoral soft tissue	$70
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	$70
D7520	incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45

D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrostomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350
D7875	Arthroscopy – surgical: synovectomy	$350
D7876	Arthroscopy – surgical: discectomy	$350
D7877	Arthroscopy – surgical: debridement	$350
D7880	Occlusal orthotic device, by report	$120

D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7961	Buccal / labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue - per arch	$175
D7971	Excision of pericoronal gingival	$80
D7972	Surgical reduction of fibrous tuberosity	$100
D7979	Non-surgical Sialolithotomy	$155
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60
D7999	Unspecified oral surgery procedure, by report	$350
Orthodontics		
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$1,000
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	

D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance – maxillary	
D8697	Repair of orthodontic appliance – mandibular	
D8698	Re-cement or re-bond fixed retainer – maxillary	
D8699	Re-cement or re-bond fixed retainer – mandibular	
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	
D8704	Replacement of lost or broken retainer – mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	palliative treatment of dental pain - minor procedure per visit	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	local anesthesia	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45
D9222	Deep sedation/general anesthesia - first 15 minutes	$45
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45
D9230	analgesia nitrous oxide	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60
D9248	non-intravenous conscious sedation	$65
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	No Charge
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	office visit - after regularly scheduled hours	$45
D9610	Therapeutic parenteral drug, single administration	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament	$20
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35
D9950	Occlusion analysis – mounted case	$120
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$210

D9995	Teledentistry - synchronous; real-time encounter	No Charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Charge
D9997	Dental case management - patients with special health care needs	No Charge
D9999	unspecified adjunctive procedure, by report	No Charge

Endnotes to 2024 Dental Standard Benefit Plan Designs
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
5) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
6) To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

California Dental Network

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Dental Services Agreement for General Dentists

Addendum to Attachment A

Compensation Schedule for DHMO members age six and older Enrolled in any of California Dental Network's Covered California HMO Plans

DENTIST: _____ Facility Number: _____

This Addendum to Attachment A sets forth the DENTIST's compensation under the Dental Services Agreement for General Dentist by and between California Dental Network, Inc. (CDN) and the DENTIST or DENTAL GROUP listed above for treatment of CDN Members ages six (6) years old and older enrolled in any of the *Covered California California Dental Network Dental HMO Plans* as well as the *Molina Healthcare of California Embedded Pediatric Dental Essential Health Benefits Plan*, or the *Ventura County Health Care Plan Embedded Pediatric Dental Essential Health Benefits Plan*, effective January 1, 2017.

Compensation for DHMO Members ages six and older enrolled in an these Plans includes the monthly Capitation payments listed below, the supplements for the five procedure codes listed, and Member Copayments on the included adult and child copayment schedules.

This schedule may be updated, amended, or revised by CDN at any time and shall be effective 45 days after written notice to DENTIST.

All other terms of the Dental Services Agreement for General Dentists remain unchanged.

	Monthly Capitation Payments		
Plan	**Single**	**Member +1**	**Family**
CC17GrF	$3.00	$6.00	$9.00
CC17GrC	$3.00	$6.00	$9.00
CC17InF	$3.00	$6.00	$9.00
CC17MHC	$3.00	$6.00	$9.00
VCHCP1	$3.00	$6.00	$9.00

Supplemented Procedure Codes		
Code	***Description***	***Supplement***
120	Periodic oral evaluation	$2.00
150	Comprehensive oral evaluation - new or established patient	$2.00
1110	Prophylaxis - adult	$3.50
1120	Prophylaxis - child	$3.50
1351	Sealant - per tooth	$5.00

California Dental Network

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Dental Services Agreement for General Dentists

Addendum to Attachment A

Fee-for-Service Compensation Schedule for DHMO members ages 0-5 years old Enrolled in any of California Dental Network's Covered California HMO Plans

Dental Office:_____ Facility ID Number(s): _____

This Addendum to Attachment A sets forth the DENTIST's compensation under the Dental Services Agreement for General Dentists by and between California Dental Network, Inc. (CDN) and the DENTIST or DENTAL GROUP listed above for treatment of CDN Members ages zero (0) through five (5) years old enrolled in Any of the Covered California California Dental Network Dental HMO Plans as well as the Molina Healthcare of California Embedded Pediatric Dental Essential Health Benefits Plan, or the Ventura County Health Care Plan Embedded Pediatric Dental Essential Health Benefits Plan, effective January 1, 2017.

The below fee schedule will be reimbursed, less applicable patient copayments, to all contracted General Dentists accepting the California Dental Network Covered California HMO Plans. This Addendum may be updated, amended, or revised by CDN at any time and shall be effective 45 days after written notice to DENTIST.

All other terms of the Dental Services Agreement for General Dentists remain unchanged.

Code	Description of Services	Fee
	DIAGNOSTIC	
D0120	periodic oral evaluation - established patient	$ 19.00
D0140	limited oral evaluation - problem focused	$ 14.00
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	$ 44.00
D0150	comprehensive oral evaluation - new or established patient	$ 31.00
D0160	detailed and extensive oral evaluation - problem focused, by report	$ 125.00
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	$ 94.00
D0210	intraoral - complete series of radiographic images	$ 50.00
D0220	intraoral - periapical first radiographic image	$ 13.00
D0230	intraoral - periapical each additional radiographic image	$ 4.00
D0240	intraoral - occlusal radiographic image	$ 13.00
D0250	extraoral - first radiographic image	$ 28.00
D0260	extraoral - each additional radiographic image	$ 6.00
D0270	bitewing - single radiographic image	$ 6.00
D0272	bitewings - two radiographic images	$ 13.00
D0273	bitewings - three radiographic images	$ 25.00
D0277	vertical bitewings - 7 to 8 radiographic images	$ 30.00
D0322	tomographic survey	$ 125.00
D0340	cephalometric radiographic image	$ 63.00
D0350	oral/facial photographic images obtained intraorally or extraorally	$ 8.00

Code	Description of Services	Fee
D0460	pulp vitality tests	$ 20.00
D0470	diagnostic casts	$ 94.00
D0999	unspecified diagnostic procedure, by report	$ 58.00
	PREVENTIVE	
D1110	prophylaxis - adult	$ 50.00
D1120	prophylaxis - child	$ 38.00
D1203	Topical application of fluoride – child	$ 10.00
D1204	Topical application of fluoride - adult	$ 8.00
D1206	topical application of fluoride varnish	$ 23.00
D1208	topical application of fluoride	$ 23.00
D1330	oral hygiene instructions	$ 25.00
D1351	sealant - per tooth	$ 28.00
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$ 28.00
D1510	space maintainer - fixed - unilateral	$ 150.00
D1515	space maintainer - fixed - bilateral	$ 250.00
D1525	space maintainer - removable - bilateral	$ 289.00
D1550	re-cementation of space maintainer	$ 38.00
D1555	removal of fixed space maintainer	$ 38.00
	RESTORATIVE	
D2140	amalgam - one surface, primary or permanent	$ 49.00
D2150	amalgam - two surfaces, primary or permanent	$ 60.00
D2160	amalgam - three surfaces, primary / permanent	$ 71.00
D2161	amalgam - four or more surfaces, primary or permanent	$ 75.00
D2330	resin-based composite - one surface, anterior	$ 69.00
D2331	resin-based composite - two surfaces, anterior	$ 75.00
D2332	resin-based composite - three surfaces, anterior	$ 81.00
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$ 106.00
D2390	resin-based composite crown, anterior	$ 94.00
D2391	resin-based composite - one surface, posterior	$ 49.00
D2392	resin-based composite - two surfaces, posterior	$ 60.00
D2393	resin-based composite - three surfaces, posterior	$ 71.00
D2394	resin-based composite - four or more surfaces, posterior	$ 75.00
D2542	onlay - metallic-two surfaces	$ 330.00
D2543	onlay - metallic-three surfaces	$ 392.00
D2544	onlay - metallic-four or more surfaces	$ 413.00
D2710	crown - resin-based composite (indirect)	$ 188.00
D2712	crown - ¾ resin-based composite (indirect)	$ 188.00
D2720	crown - resin with high noble metal	$ 180.00
D2722	crown - resin with noble metal	$ 275.00

Code	Description of Services	Fee
D2740	crown - porcelain/ceramic substrate	$ 475.00
D2750	crown - porcelain fused to high noble metal	$ 425.00
D2751	crown - porcelain fused to predominantly base metal	$ 475.00
D2752	crown - porcelain fused to noble metal	$ 475.00
D2780	crown - 3/4 cast high noble metal	$ 475.00
D2781	crown - 3/4 cast predominantly base metal	$ 475.00
D2782	crown - 3/4 cast noble metal	$ 425.00
D2783	crown - 3/4 porcelain/ceramic	$ 475.00
D2790	crown - full cast high noble metal	$ 425.00
D2791	crown - full cast predominantly base metal	$ 475.00
D2792	crown - full cast noble metal	$ 425.00
D2794	crown - titanium	$ 475.00
D2910	recement inlay, onlay, or partial coverage restoration	$ 38.00
D2915	recement cast or prefabricated post and core	$ 13.00
D2920	recement crown	$ 38.00
D2930	prefabricated stainless steel crown - primary tooth	$ 94.00
D2931	prefabricated stainless steel crown - permanent tooth	$ 113.00
D2932	prefabricated resin crown	$ 94.00
D2933	prefabricated stainless steel crown with resin window	$ 94.00
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	$ 40.00
D2940	protective restoration	$ 56.00
D2951	pin retention - per tooth, in addition to restoration	$ 100.00
D2952	post and core in addition to crown, indirectly fabricated	$ 94.00
D2954	prefabricated post and core in addition to crown	$ 94.00
D2955	post removal	$ 38.00
D2970	temporary crown (fractured tooth)	$ 56.00
D2971	additional procedures to construct new crown under existing partial denture framework	$ 25.00
D2980	crown repair necessitated by restorative material failure	$ 75.00
D2999	unspecified restorative procedure, by report	$ 63.00
	ENDODONTICS	
D3110	pulp cap - direct (excluding final restoration)	$ 24.00
D3120	pulp cap - indirect (excluding final restoration)	$ 24.00
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$ 89.00
D3221	pulpal debridement, primary and permanent teeth	$ 56.00
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$ 89.00
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$ 89.00
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$ 270.00
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$ 326.00

Code	Description of Services	Fee
D3330	endodontic therapy, molar (excluding final restoration)	$ 414.00
D3346	retreatment of previous root canal therapy - anterior	$ 270.00
D3347	retreatment of previous root canal therapy - bicuspid	$ 326.00
D3348	retreatment of previous root canal therapy - molar	$ 414.00
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$ 125.00
D3352	apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$ 125.00
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$ 256.00
D3410	apicoectomy - anterior	$ 125.00
D3421	apicoectomy - bicuspid (first root)	$ 125.00
D3425	apicoectomy - molar (first root)	$ 125.00
D3426	apicoectomy (each additional root)	$ 125.00
D3430	retrograde filling - per root	$ 119.00
D3450	root amputation - per root	$ 90.00
D3999	unspecified endodontic procedure, by report	$ 53.00
	PERIODONTICS	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$ 231.00
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$ 138.00
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$ 108.00
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$ 71.00
D4260	osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$ 438.00
D4261	osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$ 306.00
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$ 88.00
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$ 38.00
D4910	periodontal maintenance	$ 163.00
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	$ 56.00
	PROSTHODONTICS (removable)	
D5110	complete denture - maxillary	$ 563.00
D5120	complete denture - mandibular	$ 563.00
D5130	immediate denture - maxillary	$ 563.00
D5140	immediate denture - mandibular	$ 563.00
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$ 313.00
D5212	mandibular partial denture - resin base (including any conventional clasps,	$ 313.00

Code	Description of Services	Fee
	rests and teeth)	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 588.00
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 588.00
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	$ 180.00
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	$ 180.00
D5410	adjust complete denture - maxillary	$ 31.00
D5411	adjust complete denture - mandibular	$ 31.00
D5421	adjust partial denture - maxillary	$ 31.00
D5422	adjust partial denture - mandibular	$ 31.00
D5510	repair broken complete denture base	$ 63.00
D5520	replace missing or broken teeth - complete denture (each tooth)	$ 63.00
D5610	repair resin denture base	$ 75.00
D5620	repair cast framework	$ 288.00
D5630	repair or replace broken clasp	$ 125.00
D5640	replace broken teeth - per tooth	$ 63.00
D5650	add tooth to existing partial denture	$ 75.00
D5660	add clasp to existing partial denture	$ 125.00
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	$ 163.00
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	$ 163.00
D5710	rebase complete maxillary denture	$ 180.00
D5711	rebase complete mandibular denture	$ 180.00
D5720	rebase maxillary partial denture	$ 141.00
D5721	rebase mandibular partial denture	$ 141.00
D5730	reline complete maxillary denture (chairside)	$ 88.00
D5731	reline complete mandibular denture (chairside)	$ 88.00
D5740	reline maxillary partial denture (chairside)	$ 88.00
D5741	reline mandibular partial denture (chairside)	$ 88.00
D5750	reline complete maxillary denture (laboratory)	$ 175.00
D5751	reline complete mandibular denture (laboratory)	$ 175.00
D5760	reline maxillary partial denture (laboratory)	$ 175.00
D5761	reline mandibular partial denture (laboratory)	$ 175.00
D5850	tissue conditioning, maxillary	$ 63.00
D5851	tissue conditioning, mandibular	$ 63.00
D5860	overdenture - complete, by report	$ 563.00
D5911	facial moulage (sectional)	$ 531.00
D5912	facial moulage (complete)	$ 668.00
D5913	nasal prosthesis	$ 1,500.00
D5914	auricular prosthesis	$ 1,500.00

Code	Description of Services	Fee
D5915	orbital prosthesis	$ 750.00
D5919	facial prosthesis	$ 1,500.00
D5923	ocular prosthesis, interim	$ 1,500.00
D5924	cranial prosthesis	$ 750.00
D5925	facial augmentation implant prosthesis	$ 750.00
D5926	nasal prosthesis, replacement	$ 1,750.00
D5927	auricular prosthesis, replacement	$ 375.00
D5928	orbital prosthesis, replacement	$ 375.00
D5929	facial prosthesis, replacement	$ 375.00
D5931	obturator prosthesis, surgical	$ 1,250.00
D5932	obturator prosthesis, definitive	$ 1,875.00
D5933	obturator prosthesis, modification	$ 281.00
D5934	mandibular resection prosthesis with guide flange	$ 2,125.00
D5935	mandibular resection prosthesis without guide flange	$ 1,750.00
D5936	obturator prosthesis, interim	$ 1,125.00
D5937	trismus appliance (not for TMD treatment)	$ 156.00
D5951	feeding aid	$ 250.00
D5952	speech aid prosthesis, pediatric	$ 1,000.00
D5953	speech aid prosthesis, adult	$ 1,812.50
D5954	palatal augmentation prosthesis	$ 250.00
D5955	palatal lift prosthesis, definitive	$ 1,750.00
D5958	palatal lift prosthesis, interim	$ 1,000.00
D5959	palatal lift prosthesis, modification	$ 275.00
D5960	speech aid prosthesis, modification	$ 275.00
D5982	surgical stent	$ 156.00
D5983	radiation carrier	$ 100.00
D5984	radiation shield	$ 250.00
D5985	radiation cone locator	$ 250.00
D5986	fluoride gel carrier	$ 100.00
D5987	commissure splint	$ 156.00
D5988	surgical splint	$ 256.00
	PROSTHODONTICS (Fixed)	
D6100	implant removal, by report	$ 56.00
D6210	pontic - cast high noble metal	$ 400.00
D6211	pontic - cast predominantly base metal	$ 406.00
D6212	pontic - cast noble metal	$ 400.00
D6214	pontic - titanium	$ 378.00
D6240	pontic - porcelain fused to high noble metal	$ 400.00
D6241	pontic - porcelain fused to predominantly base metal	$ 406.00
D6245	pontic - porcelain/ceramic	$ 406.00
D6250	pontic - resin with high noble metal	$ 111.00

Code	Description of Services	Fee
D6251	pontic - resin with predominantly base metal	$ 406.00
D6252	pontic - resin with noble metal	$ 79.00
D6610	onlay - cast high noble metal, two surfaces	$ 475.00
D6611	onlay - cast high noble metal, three or more surfaces	$ 475.00
D6612	onlay - cast predominantly base metal, two surfaces	$ 475.00
D6613	onlay - cast predominantly base metal, three or more surfaces	$ 475.00
D6614	onlay - cast noble metal, two surfaces	$ 475.00
D6615	onlay - cast noble metal, three or more surfaces	$ 475.00
D6720	crown - resin with high noble metal	$ 180.00
D6721	crown - resin with predominantly base metal	$ 275.00
D6722	crown - resin with noble metal	$ 154.00
D6740	crown - porcelain/ceramic	$ 425.00
D6750	crown - porcelain fused to high noble metal	$ 475.00
D6751	crown - porcelain fused to predominantly base metal	$ 425.00
D6752	crown - porcelain fused to noble metal	$ 475.00
D6780	crown - 3/4 cast high noble metal	$ 475.00
D6781	crown - 3/4 cast predominantly base metal	$ 425.00
D6782	crown - 3/4 cast noble metal	$ 475.00
D6783	crown - 3/4 porcelain/ceramic	$ 425.00
D6790	crown - full cast high noble metal	$ 475.00
D6791	crown - full cast predominantly base metal	$ 425.00
D6792	crown - full cast noble metal	$ 475.00
D6794	crown - titanium	$ 475.00
D6930	recement fixed partial denture	$ 63.00
D6980	fixed partial denture repair necessitated by restorative material failure	$ 94.00
	ORAL AND MAXILLOFACIAL SURGERY	
D7111	extraction, coronal remnants - deciduous tooth	$ 51.00
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 51.00
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$ 106.00
D7220	removal of impacted tooth - soft tissue	$ 125.00
D7230	removal of impacted tooth - partially bony	$ 169.00
D7240	removal of impacted tooth - completely bony	$ 206.00
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	$ 294.00
D7250	surgical removal of residual tooth roots (cutting procedure)	$ 125.00
D7260	oroantral fistula closure	$ 375.00
D7261	primary closure of a sinus perforation	$ 125.00
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$ 219.00

Code	Description of Services	Fee
D7280	surgical access of an unerupted tooth	$ 125.00
D7283	placement of device to facilitate eruption of impacted tooth	$ 169.00
D7285	biopsy of oral tissue - hard (bone, tooth)	$ 125.00
D7286	biopsy of oral tissue - soft	$ 38.00
D7290	surgical repositioning of teeth	$ 169.00
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	$ 63.00
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$ 63.00
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$ 50.00
D7320	alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	$ 125.00
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$ 65.00
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	$ 250.00
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$ 625.00
D7410	excision of benign lesion up to 1.25 cm	$ 125.00
D7411	excision of benign lesion greater than 1.25 cm	$ 312.50
D7412	excision of benign lesion, complicated	$ 406.00
D7413	excision of malignant lesion up to 1.25 cm	$ 406.00
D7414	excision of malignant lesion greater than 1.25 cm	$ 500.00
D7415	excision of malignant lesion, complicated	$ 563.00
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	$ 406.00
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	$ 625.00
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$ 125.00
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$ 250.00
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$ 125.00
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$ 313.00
D7465	destruction of lesion(s) by physical or chemical method, by report	$ 63.00
D7471	removal of lateral exostosis (maxilla or mandible)	$ 125.00
D7472	removal of torus palatinus	$ 250.00
D7490	radical resection of maxilla or mandible	$ 1,500.00
D7510	incision and drainage of abscess - intraoral soft	$ 63.00
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$ 94.00
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$ 94.00
D7520	incision and drainage of abscess - extraoral soft tissue	$ 94.00

Code	Description of Services	Fee
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$ 125.00
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$ 75.00
D7540	removal of reaction producing foreign bodies, musculoskeletal system	$ 163.00
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	$ 125.00
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	$ 475.00
D7610	maxilla - open reduction (teeth immobilized, if present)	$ 1,250.00
D7620	maxilla - closed reduction (teeth immobilized, if present)	$ 625.00
D7630	mandible - open reduction (teeth immobilized, if present)	$ 1,500.00
D7640	mandible - closed reduction (teeth immobilized, if present)	$ 875.00
D7650	malar and/or zygomatic arch - open reduction	$ 625.00
D7660	malar and/or zygomatic arch - closed reduction	$ 313.00
D7670	alveolus closed reduction may include stabilization of teeth	$ 281.00
D7671	alveolus, open reduction may include stabilization of teeth	$ 344.00
D7710	maxilla open reduction	$ 1,500.00
D7720	maxilla - closed reduction	$ 1,000.00
D7730	mandible - open reduction	$ 1,500.00
D7740	mandible - closed reduction	$ 1,000.00
D7750	malar and/or zygomatic arch - open reduction	$ 625.00
D7760	malar and/or zygomatic arch-closed reduction	$ 313.00
D7770	alveolus - open reduction stabilization of teeth	$ 1,250.00
D7771	alveolus, closed reduction stabilization of teeth	$ 625.00
D7820	closed reduction of dislocation	$ 175.00
D7830	manipulation under anesthesia	$ 175.00
D7840	condylectomy	$ 1,250.00
D7850	surgical discectomy, with/without implant	$ 1,250.00
D7852	disc repair	$ 975.00
D7854	synovectomy	$ 1,000.00
D7856	myotomy	$ 1,013.00
D7858	joint reconstruction	$ 1,938.00
D7860	arthrotomy	$ 1,175.00
D7865	arthroplasty	$ 1,375.00
D7870	arthrocentesis	$ 550.00
D7872	arthroscopy - diagnosis, with/without biopsy	$ 1,000.00
D7873	arthroscopy - surgical: lavage and lysis of adhesions	$ 1,000.00
D7874	arthroscopy-surgical: disc repositioning/stable	$ 1,000.00
D7875	arthroscopy - surgical: synovectomy	$ 1,000.00
D7876	arthroscopy - surgical: discectomy	$ 1,250.00
D7877	arthroscopy - surgical: debridement	$ 1,000.00
D7880	occlusal orthotic device, by report	$ 375.00

Code	Description of Services	Fee
D7910	suture of recent small wounds up to 5 cm	$ 94.00
D7911	complicated suture - up to 5 cm	$ 106.00
D7912	complicated suture - greater than 5 cm	$ 119.00
D7920	skin graft (identify defect covered, location and type of graft)	$ 388.00
D7940	osteoplasty - for orthognathic deformities	$ 1,625.00
D7941	osteotomy - mandibular rami	$ 2,500.00
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	$ 3,500.00
D7945	osteotomy - body of mandible	$ 750.00
D7946	LeFort I (maxilla - total)	$ 1,625.00
D7947	LeFort I (maxilla - segmented)	$ 2,500.00
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft	$ 2,875.00
D7949	LeFort II or LeFort III - with bone graft	$ 3,750.00
D7950	osseous, osteoperiosteal, or cartilage graft mandible/maxilla – autogenous/nonauto. BR	$ 1,000.00
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$ 250.00
D7963	Frenuloplasty	$ 250.00
D7970	excision of hyperplastic tissue - per arch	$ 125.00
D7971	excision of pericoronal gingiva	$ 62.50
D7972	surgical reduction of fibrous tuberosity	$ 62.50
D7980	Sialolithotomy	$ 294.00
D7981	excision of salivary gland, by report	$ 651.00
D7982	Sialodochoplasty	$ 456.00
D7983	closure of salivary fistula	$ 150.00
D7990	emergency tracheotomy	$ 250.00
D7991	Coronoidectomy	$ 698.00
D7995	synthetic graft - mandible or facial bones, by report	$ 419.00
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	$ 56.00
	ADJUNCTIVE GENERAL SERVICES	
D9110	palliative (emergency) treatment of dental pain - minor procedure	$ 56.00
D9120	fixed partial denture sectioning	$ 63.00
D9210	local anesthesia not in conjunction with operative or surgical procedures	$ 56.00
D9220	deep sedation/general anesthesia - first 30 minutes	$ 114.00
D9221	deep sedation/general anesthesia - each additional 15 minutes	$ 18.00
D9230	inhalation of nitrous oxide / anxiolysis, analgesia	$ 31.00
D9241	intravenous conscious sedation/analgesia - first 30 minutes	$ 53.00
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	$ 26.00
D9248	non-intravenous conscious sedation	$ 31.00
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$ 43.00
D9410	house/extended care facility call	$ 25.00

Code	Description of Services	Fee
D9430	office visit for observation (during regularly scheduled hours)	$ 25.00
D9440	office visit - after regularly scheduled hours	$ 25.00
D9610	therapeutic parenteral drug, single administration	$ 19.00
D9910	application of desensitizing medicament	$ 54.00
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$ 19.00
D9950	occlusion analysis - mounted case	$ 225.00
D9951	occlusal adjustment - limited	$ 31.00
D9952	occlusal adjustment - complete	$ 500.00

General Dentists are not required to treat pediatric members ages zero through five years of age. DENTIST may refer pediatric members ages zero through five to a contracted pediatric dentist through the CDN Referral Authorization process.

GUIDELINES FOR GENERAL DENTISTS

Referrals

California Dental Network

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ATTENTION GENERAL DENTIST PROVIDERS

All specialty referrals require prior approval from the Plan. General Dentist Providers will be responsible for specialist fees for any specialty care direct referred without obtaining prior authorization and found on retrospective review to have been within the contractually agreed scope of the General Dentist Provider to perform.

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UTILIZATION MANGEMENT

California Dental Network
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Policy and Procedure

Policy Name:	**Utilization Management Specialty Referral Guidelines**	Policy ID:	**PLANCDN-17**
Approved By:	Quality Assurance Committee	Last Revision Date:	09/10/2021
States:	California	Last Review Date:	05/21/2024
Application:	Commercial	Effective Date:	05/22/2024

UM Specialty Referral Guidelines

Specialty Referral Guidelines have been developed with input from actively practicing providers. These Guidelines are published in the Plan's provider manual "Administrative Guidelines for General Dentists" and are formally reviewed and updated on an annual basis by the Quality Assurance Committee, composed of licensed general dentists and specialists.

California Dental Network, Inc. selects network general dentists who render the range of service that are required for graduation from dental school. These services, which are the responsibility of the network general dentists, include some root canal therapy, some extractions; Type I, Type II, and some Type III periodontal therapy; and pediatric dentistry.

When determining a California Dental Network Member's treatment plan, the dentist may identify the need for a referral of more complex procedures that require the skills of a dental specialist. California Dental Network has contracted with an extensive network of specialist to provide the needed services to Members at a pre- negotiated fee level. Member benefit levels are determined upon the benefit Plan purchased.

Authorization decisions are made based on available benefits, eligibility, and/or medical necessity at the time of decision. Plan staff is not incentivized for decisions that result in under or over utilization.

Orthodontics

General providers complete a specialty referral request including:

- Reason for referral (type of malocclusion)
- Status of dentition – pediatric, mixed or adult
- For pediatric Members on Covered California, Molina Health Care of California, and Ventura County Health Care Plan the Plan will authorize an orthodontic consultation. The contracting orthodontist will complete the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet and will submit the completed form to the Plan who verifies the medical necessity of the recommended treatment as determined by the consulting orthodontist using index form. It is the Plan's policy not to overturn the determination of medical necessity provided to the Plan by the consulting orthodontist.

Periodontics

General providers are expected to administer all phases of periodontal treatment, with the notable exception of surgery. Non-surgical therapy, which should be performed by a general provider, consists of the following:

- Complete mouth radiographic survey (periapical plus bitewings films). Panoramic radiograph is not acceptable.
- Complete full mouth periodontal charting and evaluation.
- Periodontal scaling and root planing.
- Oral hygiene instruction.
- Minor occlusal adjustment (when indicated).
- Recall visit – evaluation of treatment effectiveness and patient motivation with one of the following treatment recommendations:
- No other treatment necessary (excellent results).
- Poor patient response (reinforcement of home care instructions).
- Additional periodontal scaling and root planing by network general dentist.
- Request for referral of well-motivated patients with poor treatment results to a Plan specialist for evaluation.
- Periodontal emergencies are the responsibility of the general dentist. This would include removal of symptomatic teeth with poor to hopeless prognosis, and replacement with an interim prosthesis if indicated.

Referral Process

General provider must complete a specialty referral request form including:

- A brief case description.
- The date(s) of initial treatment, root planing(s) and re-call visit.
- Tooth numbers which may require surgery.
- Appropriate x-rays.
- Full mouth pocket charting done prior to scaling and root planing and at re-call after scaling and root planing have been completed, six sites per tooth.

Request forms are submitted to the Plan for Dental Director review. All periodontal referrals are subject to the following:

- Any procedure not specifically listed as a covered benefit.
- Exclusions and limitations of the Plan.

Oral Surgery

General providers are expected to deliver oral surgery care with exception of partially or completely bony impactions. They are also not expected to perform oral surgery on those patients whose physicians will not allow surgeries to be done in general practitioners' offices due to their heath histories. The following services are considered to be within the expected range of a general provider's clinical skills and responsibility:

- Uncomplicated extractions.
- Removal of soft tissue impactions.
- Simple surgical extractions.
- Minor surgical procedures.

Referral Process

General provider must complete a specialty referral request form including:

- adequate x-rays showing entire root tips.

Request forms are submitted to the Plan for Dental Director review. All oral surgery referrals are subject to the following:

- Any procedure not specifically listed as a covered benefit.
- Exclusions and limitations of the Plan, specifically referral for preventative extractions of pathology free asymptomatic impacted 3rd molars.

Endodontics

General providers are expected to perform standard endodontic therapy and palliative procedures on any tooth requiring such therapy, including molars. The following services are considered to be within the expected range of a general provider's clinical skills and responsibility:

- Single canal endodontic treatment.*
- Uncomplicated multiple canal endodontic treatment.*
  *If referred out, the panel office will be responsible for the reimbursement of fees charged by the specialist, less the applicable co-payments which the member will pay to the specialist at the time of service.

Endodontic therapy is not a covered benefit for teeth with, in the opinion of the referring general dentist, questionable or poor prognosis. In these cases, the patient should be informed that the Plan covers extraction and prosthetic placement only, and any endodontic therapy would be optional and at their expense.

Coverage for the specialist's endodontic therapy can only be approved by the Plan Dental Director. Therefore, emergency referral coverage cannot normally be assured over the phone. If the general provider feels he cannot do the indicated therapy, obviously he should not do so but refer the case out.

The Plan expects the general provider to be able to provide satisfactory palliative treatment to any tooth which has not previously had endodontic therapy. The emergency treatment may include pulpotomy, pulpectomy, gross pulpal debridement, incise and drain, occlusal adjustment, antibiotics and analgesics, and should be rendered even if the completed root canal therapy is beyond the scope of the general provider. Unique exceptions must be clearly documented to the Plan.

For emergency endodontic cases please assure that:

- Adequate x-rays are sent to the specialist. X-rays outside the panel office are not a covered benefit.
- The member is informed that the endodontist should perform only the emergency pain relief procedures, and that other work done without prior authorization may not be a Plan benefit and may be their total financial obligation.
- The member's records are thoroughly documented as to the reason why therapy could not be done in your office.

The Plan Dental Director will review each case separately to determine whether the financial responsibility lies with the Plan or the general provider. For the Plan to accept the responsibility, the following must be present:

In the opinion of the referring general dentist, the tooth involved must be critical to the case (i.e. part of an otherwise sound existing bridge, the only distal abutment on a case successfully treated with a partial, a tooth having an existing sound crown on an arch having no missing teeth, etc.).

Otherwise the Plan only covers for an extraction and prosthesis and the endodontist's fees would be the responsibility of the panel office.

Some reason has to be present which makes treatment by a general provider contraindicated (i.e. failure of an existing root canal, periapical pathology remaining after standard therapy and healing time, discovery of calcified canals, or of broken instruments during therapy). In the last two cases, working x-rays with files in place must be sent to the Plan for verify complication.

Referral Process

To confirm the above conditions the general provider must submit the following to the Plan for any endodontic referral:

- Full mouth x-rays or bilateral bitewing x-rays showing integrity of arches.
- Specific reasons why root canal therapy cannot be done by the general provider.
- All working x-rays with rubber dam and files in place demonstrating complications such as calcifications preventing complete instrumentation of canals.
- Chart entries documenting complications preventing therapy.
- Prognosis of tooth including all additional procedures (such as crown lengthening or other periodontal therapy) needed to ensure the long term prognosis.
- Date of any previous root canal therapy, if applicable.
- Symptoms, if any, of patient.

Reasons which are not acceptable to the Plan for referral include:

- Inadequate access due to physical or behavioral limitations of the member. In this case the Plan covers for extraction and prosthetic replacement only. (Refer to Plan Exclusions)
- The panel office not having the proper size instruments. In this case endodontist's fees would be the responsibility of the general provider.

Request forms are submitted to the Plan for Dental Director review. All endodontic referrals are subject to the following:

- Any procedure not specifically listed as a covered benefit.
- Exclusions and limitations of the Plan.

For all cases that are referred out, please call the Plan and inform us of the necessity for the referral. Although the claims processors cannot authorize or guarantee coverage outside the general provider office, they can expedite the referral to be reviewed by the Plan Dental Director.

Pedodontics

The following services are considered to be within the expected range of a general provider's clinical skills and responsibility:

- Routine dental care for all children.

If the general provider is unable to treat children age five and under, a child can be referred to a specialist only after making two attempts to treat the child, with the exception of patients age three and under who may be referred after one attempt; and those children enrolled under California Marketplace Plans (including the CDN Covered California Family Dental HMO Plan, Group or Individual, CDN Covered California Children's Dental

HMO, Group, Molina Healthcare of California Embedded Pediatric Dental Plan, and Ventura County Health Care Plan Embedded Pediatric Dental Plan) who can be referred to a pediatric dentist after one attempt at any age.

All pedodontic referrals are subject to the following:

- Any procedure not specifically listed as a covered benefit.
- Exclusions and limitations of the Plan.

Medical Necessity

California Dental Network has established a policy and process to ensure consistent and equitable determination of coverage for certain covered dental services. There is not available at this time standards set forth by the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Dental Association, which can be utilized for the purpose of addressing medical necessity and the appropriateness of care. In lieu of a defined standard, California Dental Network maintains open communication with all interested parties. This includes discussion and input from local Providers, CDN Peer Review Committee Members, and other licensed Dental Plan Dental Directors through the Quality Management Committee of the California Association of Dental Plans.

The written standards utilized in the process of benefit determination includes the state Medicaid guidelines, educational materials published by the American Dental Association, Plan benefit description documents as well as the information contained in the current Code of Dental Terminology published by the American Dental Association. California Dental Network refers any questionable services for evaluation to the California Dental Network Peer Review Committee or independent peer review if requested to do so by a treating Provider.

Criteria are reviewed on a yearly basis as part of the Utilization Management Program annual review.

The determination of medical necessity is necessary for prior authorization or retrospective review for claims processing. The Dental Director considers all submitted documentation in the final determination of medical necessity.

Medical necessity is defined by the Plan as services that must:

- Be necessary to protect life, to prevent significant illness or disability or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs. Consideration for individual cultures, races, ethnic backgrounds, religion, age, comorbidities, complications, progress of treatment, psychosocial situation and home environment is applied, when applicable and characteristics of the local delivery system in a manner that respects the worth of the individual and protects and preserves the Members dignity.
- Be consistent with generally accepted professional medical standards
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available
- Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the Provider

The fact that a physician has prescribed, recommended or approved medical or allied care, goods or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity.

In the event that the Dental Director is unable to determine medical necessity due to the medical implications of treatment, the Dental Director refers such review to the Plan Peer Review Committee for review.

The process for post stabilization care is as follows:

- Medically necessary, non-emergency services needed to ensure the member remains stabilized after an emergency has been provided by the Provider
- Post-stabilization care outside of the plan may be covered if the care was prior approved or California Dental Network could not be contacted for prior approval. In the event of an emergent/urgent situation, the prior authorization requirement is waived and the Provider may perform the services and submit for retrospective review

The member will be covered under emergency care until treatment is performed.

Medically Necessary Orthodontia as applicable for decisions for members covered under Molina Health Care of California, Covered California, and Ventura County Health Care Plan.

Criteria for Medically Necessary Orthodontic Services

Comprehensive orthodontic treatment is considered medically necessary for members with handicapping malocclusion, cleft palate and craniofacial anomalies.

a. Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
b. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 18 and shall be prior authorized.
c. Only those cases with permanent dentition shall be considered for
d. 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.
e. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
f. 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.
g. The automatic qualifying conditions are:
    a. 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,
    b. craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    c. a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    d. a crossbite of individual anterior teeth causing destruction of soft tissue,
    e. an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    f. 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.
h. When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:
    a. when the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or

b. when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available, then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.
c. When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.
d. If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.
e. If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.
f. If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

All Other Medical Necessity decisions for members covered under Molina Health Care of California Plan

Clinical Criteria

The clinical criteria outlined in this section are applicable to Dental Specialists seeking to perform dental treatment that is beyond the scope of a Primary Dentist. Primary Dentists are not required to submit authorizations or documentation for routine dental treatment. The criteria outlined in CDN's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for authorization and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request.

For all procedures, every Provider in the California Dental Network program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the

Provider's office as well as in the office of California Dental Network. The Provider will be notified in writing of the results and findings of the audit.

California Dental Network providers are required to maintain comprehensive treatment records that meet professional standards for risk management.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the California Dental Network Provider Panel.

Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

- Appropriate diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure code for specific requirements.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

Criteria

- The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.
- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.

Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi- surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
- A request for a crown following root canal therapy must meet the following criteria
- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post- operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

- Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.
- Root canal therapy must meet the following criteria:
- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

In cases where the root canal filling does not meet CDN's treatment standards, CDN can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after CDN reviews the circumstances.

Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

- Documentation needed for authorization of procedure:
- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.

Stainless Steel Crowns on permanent teeth are expected to last five years. Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.

Criteria for Authorization of Operating Room (OR) Cases Documentation needed for authorization of procedure:

- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.
- All Operating Room (OR) Cases Must be Authorized.

Criteria

In most cases, OR will be authorized (for procedures covered by Health Plan) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of
- Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

Approved Cases:

Provider must contact the Health Plan for authorization for the facility. Provider should submit services to CDN for authorization. Upon receipt of approval for services from CDN, Provider should contact Health Plan for facility authorization at the number below. 888-858-2150

Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.

Treatment rendered without necessary authorization will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

General

- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- The replacement teeth should be anatomically full sized teeth.
- Lost, stolen or damaged and un-repairable appliance will be replaced only if replacement is needed due to circumstances beyond the recipient's control.

Authorizations for Removable prosthesis will not meet criteria:

- If the member has already received a prosthesis within the benefit limitation period.

Criteria

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.
- If there is a pre-existing prosthesis, please review the benefit limitations in the to determine if the member is eligible for a replacement.

Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed.

The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.

When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment. Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

Criteria for General Anesthesia and Intravenous (IV) Sedation Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.

Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

- Requests for general anesthesia or IV sedation will be authorized (for procedures Covered by Health Plan) if any of the following criteria are met:
- Extensive or complex oral surgical procedures such as:
- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.

- Radical excision of lesions in excess of 1.25 cm. And/or one of the following medical conditions:
- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non- compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Criteria

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
    - Radiographic evidence of root surface calculus.
    - Radiographic evidence of noticeable loss of bone support.

Revision History

Date:	Description
09/10/2021	Conversion to revised policy and procedure format and naming convention.

Utilization	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**SECOND OPINION POLICY**	Policy ID:	**PLANCDN-19**
	Approved By:	Quality Assurance Committee	Last Revision Date:	05/05/2015
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Utilization Management
Second Opinion

Purpose

This policy establishes a framework for CDN to provide second opinion access to members seeking a second opinion about their dental care. A second opinion is encouraged as a positive component of quality of care.

Policy

It is the policy of California Dental Network that a second opinion obtained from a participating panel provider will be a covered benefit. The covered benefit will have a $10.00 copayment for all non-Covered California Plans and will need an approval from CDN before proceeding.

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 on 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 the Plan's Dental Director for consideration.

Process

- Members may obtain a second opinion by contacting the California Dental Network Customer Service Department toll-free at (877) 4-DENTAL (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 our 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 copayment. 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.
- The second opinion provider, upon completion of a consultation, documents any findings and returns the form to the Plan. The Member may remain with the current provider or, based upon the findings,

transfer to the second opinion provider for treatment.

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 affect 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 POLICY

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.

Statutory/Regulatory Citations:

- N/A

Revision History

Date:	Description
05/05/2015	Approval and Adoption

UTILIZATION MANGEMENT	California Dental Network A DentaQuest company		
	Policy and Procedure		
	Policy Name:	**Utilization Management Emergency Authorizations**	Policy ID:	**PLANCDN-21**
	Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Utilization Management
Emergency Authorizations

California Dental Network has established and implemented guidelines for UM Emergency Authorizations.

Emergency Telephone Authorizations

Emergency telephone authorizations for referrals can be given only for the service(s) that treat(s) the emergency condition, and would have been authorized had the emergency situation not arisen (i.e. services that are covered benefits on the patient's Plan).

Approval Guidelines.

- The general provider must attempt to authorize all emergency referrals with the Plan. If the Plan office cannot be reached, the general provider and Member may select a specialist of their choice from the list of Plan contracted specialists.
- Emergency authorization will only be given in cases where the treatment is necessary to alleviate the immediate pain and is beyond the general provider's clinical skills.
- Emergency endodontic referrals must include periodontal and restorative prognosis along with the reason the general provider cannot perform the necessary palliative treatment.
- Emergency pedodontic referrals are covered if the general dentist has attempted to establish a doctor-patient relationship and been unsuccessful. Emergency pedodontic referral authorizations are limited to the tooth or area causing the pain.
- Emergency oral surgery referral authorizations are limited to single teeth with pain and pathology and general dentist must be unable to manage the pain.
- Emergency referral authorizations are limited to the tooth or area causing the pain or precipitating the emergency condition.
- Emergency authorizations are valid for 72 hours.
- Emergency referral authorization will not be given for non-covered benefits.
- Emergency authorizations will not be given for Periodontics or Orthodontics. Temporary or palliative treatment for periodontic or orthodontic problems is the responsibility of the panel general dentist.
- All emergency referral requests are approved by the Dental Director or authorized staff. Therefore, accurate information must be given over the telephone. Authorization can only be given in cases when the treatment necessary to relieve the patient of immediate pain is beyond the scope of the general provider.
- Once the emergency referral has been authorized, the general provider must submit the appropriate

referral request documentation to the Plan. The Dental Director will review the request for appropriateness. If the Dental Director determines the referral did not meet the criteria of necessity for a dental emergency, or it failed to follow the emergency referral authorization guidelines, the general provider will be responsible for payment of the treating specialist's fee. The general provider may appeal a denial by contacting the Plan Dental Director.

Urgent/Emergent Referrals

General providers are contracted to treat dental emergencies whenever possible. A general provider may refer to a specialist when the treatment is beyond the scope of training and expertise of the general provider. Emergency specialty referral can be obtained by telephone in cases requiring immediate, emergency care for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen conditions, which if not diagnosed and treated, would lead to unnecessary loss of dentition, dental or medical dysfunction or any condition which may result in disability or death or which may have serious adverse health consequences if not treated immediately and covers only those services required for alleviation of/or relief of such conditions.

If, in the opinion of the referring provider, the referral constitutes a medical emergency, the referring provider must inform the Plan at the time of referral. A decision will be made by the Dental Director in the same business day. If the Dental Director is not available, authorization will be given based upon the identified medical necessity.

In the event that an independent medical review is requested for life threatening or seriously debilitating illness, the Plan's personnel will take the information and forward immediately for review and decision. Life threatening illnesses are defined as either:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Seriously debilitating illnesses are defined as diseases or conditions that cause major irreversible morbidity.

A Member may request an independent medical review within five days of denial.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1363.5(b)(4)
- CA Health and Safety Code section 1367.01(d)
- CA Health and Safety Code section 1367.01(h)(1-5)
- CA Health and Safety Code section 1374.30(i)

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
8/18/2021	Updates based on DMHC TAG Review
11/16/2022	Updates based on annual review.

California Dental Network, Inc.

23291 Mill Creek Dr. Suite 100
Laguna Hills, CA 92653
Phone (714)479-0777: Toll-Free (877) 4-DENTAL: Fax (714)479-0779

SECOND OPINION FORM

Date of Request: _____

Name of Subscriber: _____ ID#: _____

Name of Patient: _____ Relationship: ☐ Self ☐ Spouse ☐ Dependent

Current Facility #: _____ Treating Provider Name: _____

Reason for Second Opinion: _____

_____

_____

_____

Signature of Referring Provider: _____

Plan Approval: _____ Date of Approved: _____

Referred to Provider: _____ Facility # : _____

Location Address: _____ Telephone #: _____

THIS SECTION TO BE COMPLETED BY SECOND OPINION PROVIDER

Date of Appointment: _____

Second Opinion Findings and Recommendation: _____

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____

FOR PLAN USE ONLY

Patient Response: _____

_____

_____

_____

Transfer Requested? YES NO If yes, effective date of transfer: _____

California DENTAL NETWORK, INC
23291 Mill Creek Drive, Suite 100, Laguna Hills, CA 92653
(877) 4-DENTAL (433-6825) • Fax (949) 830-1655

Specialty Referral Form

Prepaid Plan #_____.
Member #_____.
Authorization #_____.

Provider Name_____Facility #_____.
Address_____Phone_____.
City_____State_____Zip_____.

Patient Name_____SS#_____.
Address_____Birthdate_____.
City_____State_____Zip_____.

Subscriber Name _____SS#_____Employer_____. Phone_____.

Please submit with all documentation and radiographs required for each specialty category requested.

☐ **Periodontics:** GP is responsible for all Phase I therapy and perio emergencies. Patient must have completed Phase I therapy (root planing or perio maintenance) within past 6 months . Submit full mouth radiographs, periodontal charting. Panoramic &/or bitewings are not acceptable.

Case type (circle) I II III IV
☐ Full mouth periodontal pocket charting enclosed
☐ Full mouth radiographs enclosed (panoramic or bite-wings not acceptable)
☐ Other (please describe below)

Dates of root planing (max 2 quads/visit)
UR_____UL_____.
LR_____LL_____.
Patient motivation (circle) Good Fair Poor

If root planing over 6 months ago, dates of all subsequent perio maintenance/hygiene_____.
_____.

☐ **Endodontics:** GP is responsible for diagnosis and treatment of all anterior, bicuspid, & routine molar endodontics and for providing palliative treatment (pulpotomy, pulpectomy, incise & drain, antibiotics &/or analgesics) even if tooth must be referred out for definitive treatment. Patients referred for diagnostic purposes will be referred back to GP for treatment once endodontist has confirmed diagnosis. Submit pre-treatment periapical radiographs.

Tooth #(s)_____ Check reason(s) for referral below

☐ Calcified/inaccessible canals: If calcification not conclusively shown on radiograph, must submit with files & rubber dam in place showing inability to reach apex.
☐ Mid-treatment complications (broken file, perforation, etc.) Describe below & submit with pre-op & mid treatment periapical radiographs.
☐ Tooth with existing, sound crown or bridge that will not be replaced & GP feels excessive risk of perforation. (If C&B to be replaced: GP to remove & attempt tx.)
☐ Retreatment, apico/retrofill. Date of initial therapy _____ Was initial therapy performed by referring office? (circle) Y N

Missing teeth in arch other than 3rd molars? (circle) Y N Missing tooth #'s_____
Does patient have an existing sound prosthesis to replace these teeth? (circle) Y N
Does tooth in question oppose a natural tooth or present/planned prosthesis? (circle) Y N
☐ Other (please describe below)

☐ **Pedodontics:** For unmanageable patients under age six. Medically compromised or developmentally disabled patients age six and over will be subject to plan review. Please attach a physician's statement of condition & describe below.

Child's age _____ 1 date attempted treatment for child under 3_____.
2 dates attempted treatment for child 3 & over (1)_____(2)_____.
Describe_____.

☐ **Orthodontics:** No need to submit radiographs.

Patient age _____
Classification of malocclusion_____.
Retreatment? (circle) Y N

☐ **Oral Surgery:** GP is responsible for routine, simple surgical & soft tissue impaction extractions. There is no coverage for preventive extraction of assymptomatic nonpathologic erupted or impacted teeth, or extractions for orthodontic purposes. Treatment of cysts, tumors & neoplasms is not covered. Refer to patient's medical insurance. Oral surgery referral is considered for individual symptomatic or pathologically involved partial or full bony impactions, and difficult surgical or soft tissue extractions of pathologic/symptomatic teeth. List tooth numbers requested & describe symptoms/pathology for each tooth requested and reason GP cannot perform tx.

Tooth Number	Eruption Status FB,PB,ST,SG,RT	Symptoms/Pathology Necessitating Extraction At This Time	Why GP Cannot Perform Extraction

FB = Full bony, PB = Part bony, ST = Soft tissue, SG = Surgical erupted, RT = Surgical root tip removal

Medically compromised patient requiring specialist treatment, please submit physician note documenting condition (referrals for health or behavioral reasons are not covered, but patient may be eligible for discounted service upon review).

☐ Other (please describe below)

☐ **Other – Please describe**_____.
_____.
_____.
_____.

Signature of referring Dr._____Date_____.

Submit with periapical or panoramic films that clearly show each tooth in its entirety. Radiographs are not a covered benefit at the specialist's office. Please submit with all indicated radiographs/documentation. Failure to provide required documentation may result in delay or denial of authorization. Emergency referrals should be called or faxed to Plan, then mail in all supporting documentation and radiographs. All emergency referrals are subject to retrospective review by the Dental Director. Referring office will be responsible for all specialist costs for procedures found on retrospective review to have been inappropriately referred.

WHITE – PLAN COPY YELLOW – PATIENT COPY PINK - SPECIALIST COPY GOLD – DENTAL OFFICE COPY

GUIDELINES FOR GENERAL DENTISTS

Quality Management

California Dental Network

A DentaQuest company

QUALITY MANAGEMENT	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Quality Management Program Description**	Policy ID:	**PLANCDN-50**
	Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Quality Management Program Description

California Dental Network (CDN) maintains a Quality Assurance Program (QAP) that is capable of performing mandated peer review and quality of care functions. In performing its functions, the QAP utilizes 7 major tools: 1) Provider Credentialing and Recredentialling, 2) Periodic Provider Office Assurance Assessment, 3) Member Satisfaction Surveys, 4) Provider Grievance tracking, 5) Member Grievance tracking, 6) Access Monitoring, and 7) Utilization Review. Data collected through each of these processes is accumulated, summarized, and reported quarterly by the Dental Director (DD) to the Plan's Quality Assurance Committee (QAC) and Peer Review Committee (PRC). Through these Committees the information is reported to the Public Policy Committee and to the President and Board of Directors. Evaluations, comments, and recommendations from these entities are communicated back through the Dental Director to Plan departments and the Quality Assurance support staff. All component processes, and the policies from which they are derived, are subject to ongoing review and revision by the QAC.

To perform their functions free of any conflict of interest, QAP participants must operate without undue influence from the Plan's administrative and financial management. This autonomy is assured by an organizational structure that separates the QA structure from administrative and financial management. The exception to this general rule is made for the Dental Director (DD), who reports to California Dental Network's President as well as the CDN Board of Directors, to assure that quality of care issues can be brought to the attention of the Plan's highest executive without restriction.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

QUALITY MANGEMENT	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Quality Management Plan of Corrective Action for Providers**	Policy ID:	**PLANCDN-51**
	Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
	States:	California	Last Review Date:	05/21/2022
	Application:	Commercial	Effective Date:	05/22/2024

Quality Management Plan of
Corrective Action for Providers

If either the DD or the QAC confirms a problem, the DD, acting alone or through the direction of the QAC, will initiate corrective proceedings. In general, California Dental Network assesses the potential for correction and improvement and then acts appropriately. At a facility, any deficiencies based upon QA indicators, access standards, utilization standards or contractual obligations eventually fall into one of two categories.

Uncorrectable Problems
For issues deemed uncorrectable, termination proceedings will be followed, per contractual agreement, and, if appropriate, the Board of Dental Examiners will be notified according to the established guidelines of the State of California, as well as the National Healthcare Integrity and Protection Databank (HIPDB).

Fair Hearing
Where the Plan concludes in writing that its decision to deny, suspend, limit or terminate a Provider Agreement is based on a medical/dental disciplinary cause or reason, the affected Provider will be entitled to request a hearing under the Judicial Review Hearing Plan. For purposes of this Judicial Review Hearing Plan', the term "medical/dental disciplinary reason" shall refer to an aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

805 Reports
Section 805 of the California Business and Professional Code requires the reporting of Health care practitioners who have had an adverse action taken against them for medical disciplinary cause or reason. When California Dental concludes in writing its decision to deny, suspend, limit or terminate a provider's contract, an 805 report will be filed with the Dental Board.

The Plan's General Counsel will be responsible for carrying out 805 reporting for CDN whenever there is decision by the Peer Review Committee to deny, suspend, limit or terminate a provider's contract based upon a dental disciplinary cause or reason. A dental disciplinary cause or reason refers to an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

An 805 Report must be filed within 15 days from the date that:

1. The Peer Review Committee denies or rejects a potential provider's application to be part of the Plan contracted provider network for dental disciplinary cause or reason
2. A provider's contract is terminated for a dental disciplinary cause or reason
3. Restrictions are imposed, or voluntarily accepted, on a provider's contract, for a total of 30 days or more within any 12 month period for dental disciplinary reasons
4. A resignation, leave of absence, withdrawal or abandonment of application occurs after receiving notice of a pending investigation initiated for dental disciplinary cause or reason

A copy of the 805 report, and a notice advising the provider of his or her right to submit additional statements or other information pursuant to Section 800, is sent by the peer review body to the provider named in the report. The information to be reported in an 805 report includes the name and license number of the provider involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report will also be made within 30 days following the date the provider is deemed to have satisfied any terms, conditions, or sanctions, imposed as disciplinary action by the reporting peer review body.

Correctable Problems
For issues deemed correctable, again the DD, acting alone or through the direction of the QAC, will inform the provider of the Plan's findings and recommendations to correct the situation. If the office is unwilling to comply, termination proceedings will be initiated as stated above. If the office is willing to comply, the DD, depending on the seriousness of the situation, may request the provider to propose a Corrective Action Plan (CAP). If the CAP is deemed adequate to correct the problem, the DD will allow the office to initiate the Corrective Action and will schedule a re-audit to evaluate the effectiveness of the correction within the timing of which will depend upon the nature and severity of the problem.

If a Quality Assurance Assessment reveals critical deficiencies, the provider is notified and a CAP is requested. The DD reviews all submitted CAPs and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the DD or QAC (as per Section VII, Combined Audit Scoring) as to whether additional procedures (such as follow up visit by Plan representative or demand or follow up audit) are needed prior to the next periodic audit. If a provider fails to adequately respond to a CAP request or if a re-audit is failed, the facility may be re-audited, closed to new Members or terminated. The matter can also be heard by the PRC. If the re-audit is passed, the office will be scheduled for its next periodic audit.

An unsatisfactory finding may be uncovered by any of the five major QA tools of the QAP (Provider Office Audits, Member Satisfaction Surveys, Utilization Review, Grievances Tracking, and Office Accessibility Review). The finding may prompt the DD, QAC or PRC to request a CAP, to order an on-demand office audit, or to shorten the re-audit interval. If an on-demand audit is required, it is performed within 30 to 120 days. The DD reviews the results of an on-demand audit. As needed, the DD then forwards the result to the appropriate committee. After considering the audit results with any other appropriate data, the office can be placed on a periodic review schedule, re-audited again on- demand, closed to new Members until successful passage of a re-audit, or be terminated.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

QUALITY MANAGEMENT

California Dental Network
A DentaQuest company

Policy and Procedure

Policy Name:	**Quality Management Scope of Activities**	Policy ID:	**PLANCDN-52**
Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
States:	California	Last Review Date:	05/21/2024
Application:	Commercial	Effective Date:	05/22/2024

Quality Management Scope of Activities

A: Provider Credentialing

California Dental Network has policies and procedures in place to ensure that all providers are licensed and certified, as required by law, and that provider locations are capable of delivering adequate levels of care to Members

See Appendix G: Credentialing for the full CDN Credentialing Policies and Procedures.

C: Periodic Provider Quality Assurance Assessment

The key steps in California Dental Network's Quality Assurance Assessment are:

- The assignment and delegation of responsibility for quality assessment and improvement of care or services

California Dental Network has delegated primary responsibility to the Plan's DD, Assistant DD(s) (as membership grows), and two oversight bodies, the QAC and the PRC. Responsibility for routine QA functions is delegated to QAC and PRC members, the Plan's QA Coordinator, Plan dental consultants, and representatives of the California Dental Network Provider Relations and Customer Service Departments.

- The delineation of the scope of care or services

The scope of dental care expected under the auspices of the Plan is defined by the QAC with major contributions by the PRC and DD. The QAC also accepts input from providers, Members, groups and outside third parties, including regulatory and administrative agencies. The delineation of scope allows the QAC to determine the activities to be evaluated for quality, appropriateness, efficiency and effectiveness. Current areas evaluated by the Plan include diagnostic and treatment procedures, dental charts and records, the prescription and dispensing of drugs and medications, patient satisfaction, patient access to care, utilization, emergency services, specialty referral, radiology, and clinical performance and outcome.

- The identification of the important aspects of care or services

The QAC and DD analyze each area to be evaluated to determine the critical characteristics of each.

- The identification of variables (both measures and indicators) for the important aspects of care or services

The QAC specifies and approves the items and conditions to be accessed. These variables are subject to on-going review and revision in response to changing dental therapeutics and technology, as well as legal changes in the professional environment.

- The establishment of comparison guidelines and thresholds

The Plan classifies all variables as indicators (Level 1 variables) or measures (Level 2 variables). All identified indicators have a specified performance level that, if not obtained, may demonstrate the existence of a quality of care problem or a more urgent need. If deficiencies are found involving indicators of care, a CAP from the provider is required, regardless of the combined audit score.

The Plan both identifies indicators and sets their appropriate thresholds by using five factors to analyze each variable. Three of these factors assess the potential adverse effect on patient's health, if there is non-compliance with the stated criteria. Another factor is based on a consideration of legal obligations for dentists and the rights of patients. The final factor reflects the variable's uniqueness by estimating its correlation to other related variables for the same aspect of care. The five factors used are:

1. Severity of the potential adverse effect on health

If the potential adverse effect is more severe, it is more likely that the variable will be used as an indicator.

2. Scope of the potential adverse effect on health

If the potential adverse effect is more limited in area or scope, it is more likely that the variable will be used as a measure. Conversely, an adverse effect on the general health of the patient is more likely to be associated with an indicator.

3. Reversibility of the potential adverse effect on health

If a deficiency can result in a pathological condition that is irreversible, then it is more likely that the variable will be used as an indicator. Conversely, if a self-limiting condition results, then the variable is more likely a measure.

4. The impact of legal obligations and patient's rights

A variable is more likely to be considered an indicator if it also reflects a legal obligation for a practicing dentist or a fundamental patient right such as the right to make an informed decision regarding treatment.

5. The estimated correlation of the variable with other stated variables

A variable, which is closely correlated, with other variables, is more likely to be viewed as a measure rather than an indicator.

- The collection and organization of data

The responsibility for this step is primarily delegated to professional consultants and/or authorized representatives of the Plans' Provider Relations Department. The function involves the review of the physical environment of the provider's office, an audit quality assessment of a sample of Member charts, and the validation of any submitted access and utilization reports for the facility. Only licensed dentists who are employed or contracted by the Plan perform the review of charts. The original charts are not removed from the dental facility. Should a chart require off-site review, only copies of the records will be transported off-site. All prevailing laws and statutes will be observed in the handling and storage of copied records. All reviewers and oversight committee members and QA participants with access to patient charts (or copies thereof) or the results of a facility chart audit assessment must sign and adhere to the confidentiality guidelines of the Plan's QAP.

- The evaluation of the performance comparison data

The collected data is accessed and compared to guidelines and thresholds. For indicators of care, the violation of a specified threshold indicates a potential problem or area for improvement that must be addressed by the provider in a timely manner. Any areas of concern reflecting the performance on audit quality assessment measures of care are also documented.

- The formulation and taking of corrective action

Notification to the provider of the facility's audit assessment results must include a request for a CAP for any and all identified deficient indicators. If no deficient indicators are identified the Plan may still elect to

request a CAP, if deemed appropriate evidence of a problem or area for improvement exists. If a CAP is requested, the provider is instructed to discuss both deficient indicators and areas of concern.

- Follow-up and evaluation on corrective action

If a CAP is required, the Dental Director or Quality Assurance Committee will review the CAP and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the DD or QAC (as per Section Combined Assessment Scoring) as to which procedures (such as shortened re-assessment intervals, follow up visit by Plan representative, or demand or follow up assessment) are needed prior to the next periodic review. If a provider fails to adequately respond to a CAP request or if a re-assessment is failed, the DD considers the matter. At the DD's discretion the facility may receive another assessment, be closed to new Members, or be terminated. The DD may also defer a decision until the matter can be heard by the PRC.

In the event of a decision to terminate, the Plan then follows its policies and protocols to terminate its relationship with the provider. In cases of termination with cause, the Plan adheres to all legal statutory and contractual reporting requirements including 805 reporting when necessary. For actions and decisions adversely impacting the provider's right to participate, the Plan has a mechanism to fairly hear and resolve a provider's appeal or grievance against the Plan.

- Communication of the results

Within the limits of prescribed confidentiality, the results of all QA audit assessment results are made available to the involved provider, the DD, oversight committees, regulating agencies and other parties. In summary form, they are also reported to the Plan's management and Board of Directors.

Process and Frequency of Quality Assurance Assessment

Pre-assessments, scheduled assessments and assessments on-demand can be done on-site or by a combination of an on-site facility assessment and the collection of charts and x-rays for review by any of the professional review components. The Independent Quality Assurance Assessment consultant, a PRC member, the DD, an Assistant DD, a QAC member, or a professional staff member performs quality assessments.

Except for facility pre-assessments of new offices, periodic assessments of existing offices and on- demand assessments combine on-site facility and chart reviews. Chart reviews are performed by licensed dentists who are contracted or employed quality assurance consultants, PRC or QAC members, the DD, or an Assistant DD. A Provider Relations Representative may also perform facility reviews.

An initial Quality Assurance Assessment of a General Dentist provider will be performed within 12 months of when 40 or more active patients are assigned to a newly contracted provider. This assessment includes a review of the charts of assigned Plan Members as well as the dental facility. Offices already contracted have facility and chart assessments on a periodic basis. The assessment frequency may be within 3 months to 36 months, based on the findings of the assessment and on the office's previous QA assessments.

Orthodontic Quality Assurance Assessments will be performed in offices with a sufficient number of members with active and/or completed treatment.

The Plan will periodically query the active orthodontic providers to try to determine the number and names of members receiving treatment. The Plan requires that orthodontic referrals be preauthorized. When preauthorization is given, the member will be assigned to an orthodontic provider. The Plan will track the assignments by provider and will quarterly review cumulative assignment data. Any additional information that indicates orthodontic activity (such as requests by orthodontists to verify eligibility) will also be used to determine activity. When combined information from referral tracking and additional information indicates that five members have been assigned to an office, the office will be contacted by the Plan to determine actual member activity (active or completed cases in the office). When five members are confirmed to be in active or completed treatment, an orthodontic Quality Assurance Assessment will be scheduled. The orthodontic

Quality Assurance consultant will perform a facility review and will review a minimum of five plan charts. The consultant may elect, with the office's permission, to review selected non-plan charts if the available Plan charts lack significant quality issues for review.

If the Quality Assurance review is acceptable, with no major deficiencies, the facility will be scheduled for its next periodic review. The next assessment will be scheduled within 24 months. After an office has had two consecutive acceptable assessments, it will be placed on a 36-month review schedule.

If an assessment reveals critical deficiencies, the provider is notified and a CAP is requested. The DD reviews all submitted CAPs and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the DD or QAC (as per Section VII, Combined Assessment Scoring) as to which procedures (such as shortened re-assessment intervals, follow up visit by Plan representative, or demand or follow up assessment) are needed prior to the next periodic review. If a provider fails to adequately respond to a CAP request or if a re-assessment is failed, the DD considers the matter. At the DD's discretion the facility may receive another assessment, closed to new Members, or terminated. The DD may also defer a decision until the matter can be heard by the PRC.

A Potential Quality Issue (PQI) may be uncovered by any of the five major QA tools of the QAP (Provider Office Quality Assessments, Member Satisfaction Surveys, Utilization Review, Grievances Tracking, and Office Accessibility Review). The finding may prompt the DD, QAC or PRC to order an on-demand office assessment or to shorten the re-assessment interval. If an on-demand audit assessment is required, it is performed within 30 to 120 days. The DD reviews the results of an on-demand assessment. As needed, the DD then forwards the result to the appropriate committee. After considering the assessment results with any other appropriate data, the office can be placed on a periodic review schedule, re-assessed again on-demand, closed to new Members until successful passage of a re-assessment, or be terminated.

The Facility/Structure Audit Review measures compliance with the aspects of infection control, radiographic safety, occupational hazard controls, medical emergency procedures and office policies and procedures. The different infection aspects are personnel protective equipment, hepatitis B vaccination, infectious waste disposal, sterilization, disinfection and training programs. The Facility Audit Review Form also monitors provisions of preventive dental health education materials to Members. Critical indicators of the Facility/Structural Review include: a current medical emergency kit and personnel who know its location, Mobile oxygen available with positive pressure, 24 hr emergency system and doctor available, use of adequate barrier techniques, and reusable instruments and handpieces sterilized. A deficiency on any critical indicator necessitates the formulation of a Corrective Action Plan with a requirement to demonstrate that the Corrective Action has been taken.

Chart/Process Reviews

The plan uses a Dental Chart Assessment form to determine that the level of care delivered by contracted providers meets professional and legal standards of practice. The current General Dental form recognizes the following aspects of care: Medical/Dental History, Diagnostic Information, Progress Notes, Emergency Care, Diagnosis and Treatment Plan, Radiographs, Periodontics, Preventive Care, Restorative, Endodontics, Crown and Prosthetics (for fixed and removable prosthodontics), Oral Surgery, Pedodontics and Continuity of Care and follows guidelines developed by the California Association of Dental Plans (CADP). For each aspect of care, appropriate variables are listed. The results for all variables are used to compute an overall chart assessment score. In addition, the QAC has designated three variables as Level 1A indicators that require consistent compliance on all reviewed charts. These critical standards are subject to ongoing review and revision. Currently they include: "complete and comprehensive health history signed by the patient/guardian," "Overall care is clinically acceptable (to the extent it is possible to determine by x-ray and available information)", and "evidence of emergency coverage on a 24-hour basis."

Chart Reviewers

The Independent On-Site Quality Assurance consultant, the DD, a PRC member or a QAC member does

chart reviews. The plan is a participating member of CADP's shared assessment warehouse and may alternatively choose to view an assessment recently preformed by another Knox-Keene licensed dental plan that has been entered into the shared assessment warehouse. In that case the Dental Director shall view the shared assessment and may choose to accept the assessment scoring or alternatively to schedule a review by a CDN contracted consultant, the DD, a PRC or QAC.

Chart Selection, General Dental Offices
Charts to be reviewed are selected from the current monthly eligibility list of the dental office. The total number of subscribers divided by 100 will determine the routine of chart selection. For example, if there are 595 subscribers, then 595 divided by 100 equals 5.95. Therefore, every sixth subscriber would be chosen for chart selection. From these subscribers, the office must pull the first 20 available charts in the order in which the names were provided.

The office is sent a Quality Assessment appointment letter, which includes the list of member names that charts for the assessment are to be selected from, as well as appointment date and instructions for preparing for the assessment. The reviewer will be instructed to select ten charts from the 20 provided that fit the criteria of:

- At least five charts are adult patients with treatment plans that include more procedures than prophylaxis/hygiene.
- At least five have completed treatment and been seen for recall.
- At least one pedodontic, one restorative, one completed endodontic, one completed oral surgery, one completed prosthodontic (crown, bridge, partial, denture) and one periodontic case are included.

In the event that the reviewer finds that there are not ten charts from the 20 that fit the criteria (and offices with fewer than 50 patients active for more than two years are anticipated to have difficulty providing sufficient charts according to the chart selection criteria), the reviewer may request to see additional plan charts and/or will document the lack of acceptable charts in the Quality Assessment report. This may result in a shorter interval until the next periodic review, at the Dental Director's discretion. Offices generally do not receive Quality Assurance Assessments until 40 active Member patients are confirmed in the office. Should a previously reviewed office fall below 30 active Member patients, it may be placed in a pending status and not routinely re-assessed until the number of active Member patients increases.

In offices with a significant number of Plan members, the Plan will determine the chart selection routine to assure that the offices do not select the charts for review. A copy of the Plan's general dental and orthodontic facility and chart assessment instruments and facility and chart assessment criteria is included in the appendix of the QAP.

Combined Quality Assessment Scoring

The overall combined assessment score is based on the scores received in both the Facility Reviews and Chart Reviews. The percentage score for each of these components is halved, and then added together. The Plan has four ratings for combined assessment scores:

Acceptable
Combined scores of 90% and greater.

Acceptable with Recommendations
Combined scores less than 90%, but equal to or greater than 80%.

Marginally Acceptable
Combined scores less than 80%, but equal to or greater than 70%.

Unacceptable

Combined scores less than 70%.

Facility scores and each section score of the process/chart assessment will also be looked at separately. A combined score of less than 70% or less than 70% on the facility score will be considered unacceptable. The office will be required to submit a CAP and will be re-reviewed in *3-6 months,* following acceptance of submitted CAP. (In the case of facility review below 70% with otherwise acceptable process assessment score a trained provider relations representative will visit the office to verify that CAP has been carried out and office will be placed on 18-24 month re-assessment schedule.) Offices that post an overall process score of 70% or above but have less than 50% on any of the section totals will be placed on a 12-18 month re-assessment schedule, depending on the nature of the deficiency. Offices that post combined scores over 70% with no deficient critical indicators, facility score
=>70% and process section totals all =>50% will generally be placed on 24-month re-review (unless the DD or QAC determines a reason for a more frequent review).

If an assessment reveals critical deficiencies in the process review, the provider is notified and a CAP is requested. The DD reviews all submitted CAPs and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the DD or QAC as to whether additional procedures (such as follow up visit by Plan representative or demand or follow up audit assessment) are needed prior to the next periodic audit review. If a provider fails to adequately respond to a CAP request or if a re-audit re-assessment is failed, the facility may be re-audited re-assessed again, closed to new Members or terminated. The matter can also be heard by the PRC. If the re-audit re-assessed is passed, the office will be scheduled for its next periodic audit review.

Offices with deficient critical indicators in the facility assessment must submit a CAP. Re-assessment will depend on the nature of the critical deficiency (e.g. a receipt for purchase of an oxygen tank or emergency medical kit supplies would suffice to verify compliance with CAP, whereas an office visit would be required to verify sterilization procedures). Generally, follow up on critical deficiencies can be accomplished by a trained provider relations representative and will be scheduled, when needed, within three to six months of acceptance of the CAP.

If the office fails a CAP verification re-assessment, the office may be re-assesses again in one to three months and/or closed to new Members and/or recommended for termination.

Offices that are required to submit a CAP are given 30 days to do so. In most cases the Quality Assurance will assist the office to develop and sign off on a CAP at the time of the assessment visit. Offices who do not respond within 30 days are given an additional 15 days and advised that their office will be closed to new Members and subject to termination if response is not received in 15 working days. Offices who still do not respond are informed that they are closed to new Members and may be terminated in 15 days, if there is no response to the third notice.

3) Member Satisfaction Surveys

Member Satisfaction surveys employ a response card designed to elicit information on areas of concern, including accessibility, quality of care, staff and provider attitudes, overall satisfaction with the assigned dental office and customer service of the Plan. All members receive a Member Satisfaction survey annually with their renewal notification. Results are reviewed and tabulated quarterly and summary reports are prepared. The reports are incorporated into the Plan's QA process. There are also three major types of targeted Member surveys that may be conducted by the Plan. A survey by group may be initiated by the Plan either as a result of pro-active customer service or in response to input from a group. Survey by provider facility is done either on a scheduled basis by the Plan, on demand of the DD, or at the request of a committee. The DD or a committee may similarly request a Member survey by benefit Plan. The Member Satisfaction Survey is included in Appendix D-Assessment Procedures.

4) Provider Dispute Resolution

California Dental Network will communicate in writing to its contracted providers the Provider Dispute Resolution Process, through the Provider Manual, which is distributed at the time the provider is accepted on the panel. Non-contracted providers will be notified in writing through the Plan's specialty referral and claims processes. A toll-free number will be available for providers to submit a dispute, which is accessible from all of California Dental Network's service areas.

Dispute Resolution Process

A designated staff member will handle written or oral disputes. All disputes will be resolved within 30 days wherever possible.

The dispute resolution process is comprised of the following:

All disputes will be acknowledged within 5 working days. A letter of acknowledgement will be sent to the provider, which will include the name of the designated staff member they may contact for questions.

The designated staff member will record the dispute in the Plan's dispute resolution log. The log will maintain information such as: the date that the dispute was received, provider name, grievance type or description, and resolution date of the dispute.

The designated staff member will investigate and attempt to resolve the dispute by promptly obtaining all pertinent information. Any dispute related to quality of care issues will be given to the Plan Dental Director for review and resolution. The resolution of the dispute will be recorded in the dispute log.

The provider will receive written notification of the dispute resolution. The notification will include the process by which the resolution may be appealed if not resolved to their satisfaction.

A dispute resolution may be appealed to the Public Policy Committee by writing to the Plan within 45 days of receipt of the initial resolution. Those dispute resolutions involving quality of care may be subject to prior review by the Quality Assurance/Peer Review Committee and their recommendations forwarded to the Public Policy Committee for its use during review of the appeal.

If the Provider is dissatisfied with the Public Policy Appeal Resolution the provider may appeal to the Department of Managed Health Care's provider grievance unit.

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (1-888-HMO-2219) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 1-714-479-0777 or toll-free 1-877-4-DENTAL and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law

Expedited Resolution

If the dispute requires an immediate resolution for an urgent or emergency quality of care issue the time period for the Plan action, as set forth above shall not apply. In such cases the Plan will handle the dispute within a timeframe appropriate for the situation.

Reporting and Review

The designated Plan staff will review the dispute resolution log on a weekly basis to insure that the Plan's 30-day resolution standard will be met in all cases possible.

The designated Plan staff will compile a quarterly report of the dispute resolution log, which will be presented to the Quality of Care Quality Assurance/Peer Review and Public Policy committees for review. Any findings

or recommendations will be presented to the Board of Directors.

5) Member Dispute Resolution (Grievance) – see Section 2: Grievance and Appeals

6) *Access Monitoring*-see Section 1: Access and Availability

7) Utilization Review-see Section 3: Utilization Management

8) Identification of Potential Quality Issues (PQI's)
The Master Tracking Report of Potential Quality Issues is designed to help the Plan identify QA trends or patterns of care across the different Quality indicators that the Plan tracks. By listing in summary form all of the identified areas of concern over the past 12 months on one spreadsheet, the Plan is alerted to emerging patterns of care and can take corrective action at either the individual provider level or at the Plan level. Currently the Plan defines a possible pattern within an office as 3 total listings across all categories, in the prior 18 months.

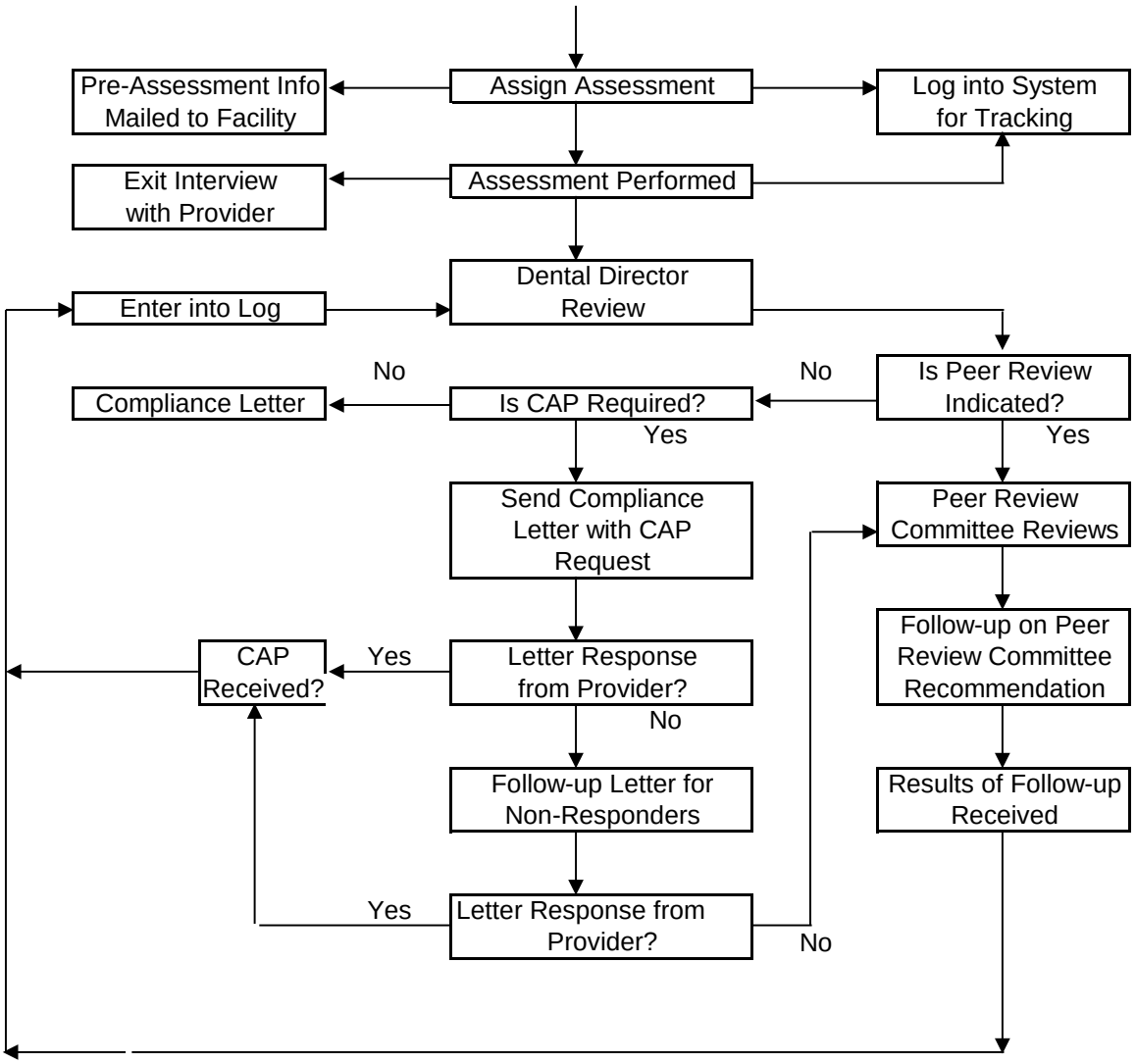
Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

CALIFORNIA DENTAL NETWORK
ASSESSMENT PROCESSING FLOWCHART



Assessment Process of Care Review Criteria

Review Criteria	Reviewer Evaluation Measures
I. DOCUMENTATION	
A. Medical History	
1. Comprehensive information collection	General medical history with information pertaining to general health and appearance, systemic disease, allergies and reactions to anesthetics. Should include a list of any current medications and/or treatment. Proactive format is recommended. Name, telephone number of physician and person to contact in an emergency. Patient must sign and date all baseline medical histories.
2. Medical follow-up	Patient comments, DDS/DMD notes, or consultation with a physician should be documented in the chart.
3. Appropriate medical alert	Should be uniform and conspicuously located on the portion of the chart used during treatment and should reflect current history.
4. Doctor signature and date	Dentist must sign and date all baseline medical histories after review with patient.
5. Periodic update	Documentation of medical history updates at appropriate intervals. Must be signed by the patient and the provider. Acceptable on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done annually.
B. Dental History/Chief Complaint	Documentation of chief complaint and pertinent information relative to patient's dental history.
C. Documentation of Baseline Intra/Extra Oral Examination	
1. Status of teeth/existing conditions	Grid or narrative of existing restorations and conditions.
2. TMJ/Occlusal evaluation	Evidence of TMJ exam or evaluation of occlusion (classification) should be determined.
3. Prosthetics	Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps,etc.
4. Status of periodontal condition	a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc. b. Evidence of baseline probing should be documented (if indicated). c. Case type of perio conditions (Type I-IV) or (Normal, Gingivitis, or Slight, Moderate or Severe Periodontitis)
5. Soft tissue/oral cancer exam	a. Evidence that soft tissue /oral cancer exam was performed initially and periodically (at least annually) b. Note of any anatomical abnormalities
D. Progress Notes	
1. Legible and in ink	Provider should be reminded that progress notes are a legal document, all should be in ink, legible and should be in detail. Corrections should be made by lining-out. Documentation of any follow-up instructions to the patient or recommendations for future care. Documentation of patient leaving the practice and reasons, if known. Documentation if any records forwarded, etc.

Assessment Process of Care Review Criteria

D. Progress Notes	
2. Signed and dated by provider	All entries must be signed or initialed and dated by the treating provider. (Per CA. Dental Practice Act, Section 1683)
3. Anesthetics	Notation in progress notes as to the type and amount of anesthetic used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used, if any)
4. Prescriptions	Medications prescribed for the patient are documented and Sig., Rx, and Disp. in the progress notes or copies of all prescriptions are kept in the chart. Note an Rx given on phone. Recommended that dental lab prescriptions be documented in the progress notes or a copy kept in the chart.
II. QUALITY OF CARE	
A. Radiographs	
1. Quantity/Frequency	a. Adequate number of radiographs to make an appropriate diagnosis and treatment plan, per current FDA guidelines. b. Recall x-rays should be based on FDA guidelines. Depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure. c. Whenever possible, radiographs should not be taken if recent acceptable films are available from another source (previous Dentist). d. Any refusal of radiographs should be documented.
2. Technical Quality	a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical films should show apices. b. Good contrast, not over or underdeveloped; no chemical stains.
3. Mounted, labeled and dated	Recent radiographs must be mounted, labeled and dated for reviewing and comparison with past radiographs.
B. Treatment Plan	
1. Present and in ink	a. Comprehensive documentation of patient needs and treatment recommendations, all documentation in ink. b. Consistent with diagnosis and clinical exam findings. c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed. d. Consultations and referrals should be noted when necessary.

Assessment Process of Care Review Criteria

B. Treatment Plan	
2. Sequenced	Case should be sequenced in order of need and consistent with diagnostic and examination findings, and in compliance with recognized accepted professional standards. (Dental Practice Act, Section 1685) A possible sequence follows: a. Relief of pain, discomfort and infection. b. Prophylaxis and instructions in preventive care. c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy. d. Periodontal treatment e. Replacement of missing teeth, or restorative treatment f. Placement of patient on recall schedule with documentation of progress notes.
3. Informed Consent	a. Documentation that treatment plan has been reviewed with the patient and that the patient understands the risks, benefits and alternatives to care. Patient should also understand the financial component of the treatment proposed. b. An appropriate form signed by the patient is recommended. Documentation that all patient's questions were answered. Evidence of a 'meeting of the minds'. c. Documentation of any refusal of recommended care.
III. TREATMENT OUTCOMES OF CARE	
A. Preventive Services	
1. Diagnosis	Documentation that prophylaxis was performed in a timely manner. Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence.
2. Oral Hygiene Instructions	Documentation of Home Care/ Oral Hygiene instructions given to patient.
3. Recall	Documentation of timely case appropriate recall of patient.
B. Operative Service	
1. Diagnosis	Recall and past radiographs used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.

Assessment Process of Care Review Criteria

C. Crown and Bridge Services	
1. Diagnosis	Recall and past radiographs used to evaluate the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
D. Endodontic Services	
1. Diagnosis	Signs and symptoms documented (if need not evident on radiographs).
2. Rubber Dam Use	Evidence of rubber dam use on working x-rays and/or documentation of use in progress notes.
D. Endodontic Services	
3. Endodontic Outcome and Follow-Up	a. Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no eivdence of extraction of recently completed endo. c. Documentation of final restoration. d. Recall follow-up recommend with PA x-ray.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
E. Periodontal Services	
1. Diagnosis	Evidence that clinical examination including pocket charting and radiographs is available to determine proper type of treatment needed.
2. Treatment per visit	Rationale for more than 2 quadrants of scaling/root planing per visit should be documented.
3. Periodontal Follow-Up/Outcome	Recall follow-up recommended with radiographs or probing.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
F. Prosthetic Services	
1. Diagnosis	Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no prosthesis exists.
2. Prosthetic Outcome and Follow-Up	a. Treatment was done in a timely manner, including necessary adjustments. b. Prognosis good for appropriate longevity.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.

Assessment Process of Care Review Criteria

G. Surgical Services	
1. Diagnosis	Radiographic and/or soft tissue / clinical exam supports treatment rendered
2. Surgical Outcome and Follow-Up	a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure. b. Documentation of post-operative instructions to patient. c. Documentation of any needed post-operative care, including suture removal.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
IV. OVERALL PATIENT CARE	Overall care is clinically acceptable (to the extent that it is possible to determine by x-rays and available information.

Assessment Structural Review Criteria

Review Criteria	Reviewer Evaluation Measures
I. Accessibility	
A. 24 Hour Emergency Contact System?	Active after hours mechanism (Answering machine, answering service, cell phone, or pager) available for 24hour / 7 day a week contact or instructions. 1. Patients informed of emergency system for 24/7 access 2. Inability to provide 24 hour access for dental emergencies is a departure from accepted standards of care.
B. Reasonable appointment scheduling for plan members?	The patients wait time to schedule an appointment should be reasonable and appropriate according to filed access standards (Individual to each Plan). 1. Initial appointment/routine appointment 2. Hygiene
C. Language Assistance Program and Documents?	Patients requiring Language Assistance can receive it. Confirm languages spoken in office- indicate in check box or via manual entry those languages spoken. Provider knows how to contact plan to obtain language assistance for patients needing translation and/or interpretation services. Provider knows to document a patient's refusal of assistance in the patient's treatment record
II. Facility and Equipment	
A. Clean, safe neat and well-maintained	Verification made that facility and equipment are clean, safe and in good repair 1. There are no visible stains or significant scarring of furniture or floors. 2. There is no debris on floors or other areas, especially patient care, reception, infection control areas and laboratories. 3. Décor should be in good taste, easily cleaned and well maintained 4. For protection of everyone, employees and patients, lighting should be sufficient to allow safe ingress/egress and to maintain good vision without fatigue. 5. Dental equipment should be appropriate and in good working condition: 5a. No equipment with obviously broken parts, visible damage, temporary repairs or grossly torn upholstery. 5b. Current certification results for equipment requiring local, state or federal certification on file at the facility. (radiographic equip/ medical waste)
B. Compliance with mercury hygiene, safety regulations?	Compliance with mercury hygiene, safety regulations. 1. Amalgamators covered. 2. Bulk mercury and scrap amalgam stored in sealed, unbreakable containers. 3. Mercury spill kit.

Assessment Structural Review Criteria

II. Facility and Equipment	
C. Nitrous Oxide Recovery System?	Verification that nitrous oxide equipment is clean, safe and in good repair. 1. No visible cracking or destruction to hoses or nose piece. 2. Recovery System with connection to exhaust or suction system. Usually requires a minimum of four hoses for this to be accomplished. 3. Fail Safe mechanism present for correct delivery of gasses.
D. Lead Apron (with thyroid collar for patient)	There should be a lead apron present with a thyroid collar. The collar does not have to be attached to the apron, but must be used on all patients when exposing radiographs. Separate thyroid collar is acceptable.
III. Emergency Procedures and Equipment	
A. Written emergency protocols?	For fire and/or natural disasters: 1. A plan indicating escape routes and staff member's responsibilities, including calling for help. 2. Exits clearly marked with exit signs. 3. Emergency numbers posted, (911, Fire, Ambulance and local 7-digit numbers in both front office and back office or lab.) Written protocol for calling for help. Note: If office protocol entails only calling 911, then this section does not apply and evaluation should be marked "N/A"
B. Medical emergency kit on-site?	Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs (per JADA 3/2002 article) are current. Staff should be aware of location of kit. Recommend staff in-service training for general use of contents.
C. Portable oxygen supply available?	Portable oxygen supply tank / ambu- bag for medical emergencies should be available. 1. Recommend tanks be maintained full and a positive pressure bag or ambu bag be available. 2. Recommend staff in-service training for use of emergency oxygen source. 3. Staff should be aware of and have access to location.
IV. Sterilization and Infection Control	
A. Sterilization and infection control protocols followed?	Verify sterilization and infection control procedures are in place. Verify staff trained in sterilization and infection control procedures and protocols. Sterilization and infection control procedures shall conform to the Dental Board of California. (DPA Section 1680dd, January 1993)
B. Protocols posted for sterilization procedures?	Protocols conspicuously posted. Dental Board of California. (DPA Section 1005b23, January 2001)
C. Weekly biological (spore) monitoring of sterilizer?	Sterilization procedures shall be monitored weekly and recorded, by appropriate methods, as required by the Dental Board of California. (DPA Section 1005b14, January 2001)

Assessment Structural Review Criteria

IV. Sterilization and Infection Control	
D. All instruments and hand-pieces properly cleaned, sterilized, and stored?	1. Contaminated instruments are properly cleaned. a. Utility gloves used. b. Ultrasonic cleaning recommended. Solutions changed per manufacture's specifications. 2. Acceptable procedures for sterilization are: a. Storage of instruments shall be in sterile bags or packs that are sealed. There should be no evidence of moisture or torn bags. Instruments must remain in sealed, sterile bags or packs until ready for use. Once opened, all instruments must be rebagged and resterilized, regardless of whether they were used or not. b. Hand-pieces must be properly sterilized between patients and bagged until use. c. Instruments, which cannot be cold-sterilized, or autoclaved, must be disposable and must be disposed of immediately after use. d. High level disinfectant should be utilized only on instruments that cannot be subjected to other methods of sterilization
E. Log kept monitoring changing of sterilization solution?	Maintain a written log indicting: 1. Acceptable EPA registered brand name of the cold sterilant (high-level disinfectant) tuberculocidal hospital disinfectant, utilized according to the manufacturer's recommendations for sterilization. 2. Indicate dates solution changed, and dates of expiration of fresh solution. 3. Indicate name of staff member making the change. (Dental Practice Act)
F. Staff wears appropriate personal protective equipment?	1. Personnel shall always use protective gloves, masks, eyewear, coats or gowns during patient care. 2. Splattered masks and garments should be replaced as necessary. 3. Gloves must be changed between patients and before leaving the operatory.
G. Proper and adequate use of barrier techniques?	1. Verification made that hard surfaces in all operatories are disinfected between patients and at the end of each day. A Cal OSHA/EPA approved solution should be used. 2. Verification made that surfaces not capable of being disinfected by routine methods should be covered with impervious materials.
H. Hand-pieces and waterlines flushed appropriately?	Operatory unit water lines shall be flushed between each patient and in the morning before use, for an appropriate amount of time (per manuf. guidelines).
I. Infection control and cross contamination prevention procedures followed in the office and laboratory?	1. The pumice pan should be changed after each use and rag wheels should be sterilized after each use or discarded. 2. Impressions, dentures and other appliances going to and coming from the laboratory should be properly rinsed and disinfected.

Facility #_____
Chart %_____
Facility %_____
Total %_____
Re-Audit Interval_____
Next Re-Audit Date_____
CAP Y/N_____

CALIFORNIA DENTAL NETWORK
DENTAL QUALITY ASSURANCE REVIEW

The intent of this review is to ensure delivery of quality dental care by providers of dental services for patients enrolled in a Knox Keene licensed Specialty Health Care Plan or other regulated Plans.

A score of 70-100 ACCEPTABLE. Re-review will be scheduled at intervals, depending on the items that the consultants wish to review, according to California Dental Network's quality assurance policy.

Below 70 points UNACCEPTABLE.

Reviewed by: _____ Date of review: _____

Name of Facility: _____ Facility # :_____

Name(s) of the owner(s):_____

Address:_____

City:_____ Zip Code: _____ Tel. _____

Number of dentists: _____ Full time: _____ Part time:_____

Number of Personnel: Chairside Assistants: _____ Admin/Clerical:_____

Lab tech: _____ Hygienists: Full time: _____ Part time:_____

Office hours:
Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____ Sat: _____

Number of operatories: _____ Ability to expand? Yes No

Parking available? Yes No

Names & License #'s of Associate Dentists:

Name	License Number	Credentials Verified?
_____	_____	Yes / No
_____	_____	Yes / No
_____	_____	Yes / No

CHART REVIEW COVER

CHART #1

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #2

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #3

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #4

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #5

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #6

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #7

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #8

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #9

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

CHART #10

Patient Name_____ Gender_____

Patient ID Number_____ Birthdate_____

PROCEDURAL AUDIT

Date: _____

Office/Provider Name: _____

Address: _____

_____

Office Id: _____

CDN Dental Representative: _____

_____

Plan: _____

Notes: _____

_____

_____

_____

_____

_____

PROCESS OF CARE Chart Ids:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

I. DOCUMENTATION

A. Medical History

1. Comprehensive information collection (408)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Medical follow-up (409)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Appropriate medical alert (410)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
4. Doctor signature and date (411)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
5. Periodic update (412)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

B. Dental History/Chief complaint

1. Dental History/Chief complaint (413)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

C. Documentation of Baseline Intra/Extra Oral Examination

1. Status of teeth/existing conditions (414)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. TMJ/Occlusion evaluation (415)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Prosthetics (416)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
4. Status of periodontal condition (417)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*5. Soft tissue/oral cancer exam (418)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

D. Progress Notes

1. Legible and in ink (419)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Signed and dated by provider (420)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

D. Progress Notes (Cont.)

3. Anesthetics notes (421)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
4. Prescriptions noted (422)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

II. QUALITY OF CARE

A. Radiographs

*1. Quantity/frequency (423)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Technical quality (424)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Mounted, labeled and dated (425)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

B. Treatment Plan

1. Present and in ink (426)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Sequenced (427)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*3. Informed consent (428)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

III. TREATMENT OUTCOMES OF CARE

A. Preventive Services

*1. Diagnosis (429)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Oral hygiene instructions (430)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Recall (431)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

B. Operative Services

*1. Diagnosis (432)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*2. Restorative outcome and follow-up (433)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Specialist Referral (434)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

C. Crown and Bridge Services

*1. Diagnosis (435)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*2. Restorative outcome and follow-up (436)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

C. Crown and Bridge Services (Cont.)

3. Specialist Referral (437)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

D. Endodontic Services

*1. Diagnosis (438)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Rubber dam use (439)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*3. Endodontic outcome and follow-up (440)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
4. Specialist Referral (441)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

E. Periodontic Services

*1. Diagnosis (442)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
2. Treatment per visit (443)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*3. Periodontal follow-up/outcome (444)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

E. Periodontic Services (Cont.)

4. Specialist Referral (445)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

F. Prosthetic Services

*1. Diagnosis (446)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*2. Prosthetic outcome and follow-up (447)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Specialist Referral (448)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

G. Surgical Services

*1. Diagnosis (449)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
*2. Surgical outcome and follow-up (450)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:
3. Specialist Referral (451)	1)	2)	3)	4)	5)
Comments:	6)	7)	8)	9)	10)
					Initial:

H. Overall Patient Care

*Overall care meets professionally (452)	1)	2)	3)	4)	5)
recognized standards	6)	7)	8)	9)	10)
Comments:					
					Initial:

*Identifies Required 100% Compliance

Office Name:_____ Date:_____

Provider ID: _____ Auditor:_____

STRUCTURAL REVIEW AUDIT

	Rating:	Comments:
I. ACCESSIBILITY		
A. 24 hour emergency contact system? (453)		
B. Reasonable appointment scheduling for plan members? (454)		
C. Language Assistance Program and Documents? (600)		
1. Posting of Interpreter Signage		
2. Provide CDN's language assistance phone number, grievance forms in English and Spanish, and verify that the provider knows how to contact the Plan for interpretation /translation services.		
3. Member's preferred language is documented in their record.		
4. If applicable, request/refusal of interpreter services is documented in the member's record.		
5. Record languages spoken at office and collect completed Language Capability Disclosure form as needed.	☐ Arabic ☐ Armenian ☐ Bengali ☐ Cantonese or Mandarin ☐ Farsi ☐ German ☐ French ☐ Hindi ☐ Korean ☐ Russian ☐ Spanish ☐ Tagalog ☐ Simplified Chinese ☐ Khmer ☐ Hmong ☐ Lao ☐ Vietnamese ☐ Other non-English (list in Comments)	
II. FACILITY AND EQUIPMENT		
A. Clean, safe, neat and well maintained? (455)		
B. Compliance with mercury hygiene, safety regulations? (456)		
C. Nitrous Oxide recovery system? (457)		
D. Lead apron (with thyroid collar) for patient? (458)		
III. EMERGENCY PROCEDURES AND EQUIPMENT		
A. Written emergency protocols? (459)		
B. Medical emergency kit on-site? (460)		

C. Portable emergency oxygen available? (461)		
IV. STERILIZATION AND INFECTION CONTROL		
A. Sterilization and infection control protocols followed? (462)		
B. Protocol posted for sterilization procedures? (463)		
C. Weekly biological (spore) monitoring of sterilizer? (464)		
D. All instruments and hand-pieces properly cleaned, sterilized, and stored? (465)		
E. Log kept monitoring changing of sterilization solutions? (466)		
F. Staff wears appropriate personal protective equipment? (467)		
G. Proper and adequate use of barrier techniques? (468)		
H. Hand-pieces & waterlines flushed appropriately? (469)		
I. Infection control and cross contamination prevention procedures followed in the office and laboratory? (470)		
Comments:		

*Identifies Required 100% Compliance

Miscellaneous/Additional Comments:

Recommended Re-Audit Interval: (Circle One)

3 mos. 6 mos. 12 mos. 18 mos. 24 mos.

Exit Interview Conducted With:

Name: Position:

I agree to make the required corrective actions prior to the next scheduled audit to achieve 100% compliance with mandatory Quality of Care Parameters (CAP):

Interviewee Signature: Signature Date:

CDN Dental Consultant:

Signature: Signature Date:

Please use these Language Identification Flashcards to assist CDN members in communicating with you and your office staff. If a Plan member requests translation services, please contact the Plan at 1-800-4-DENTAL.

LANGUAGE IDENTIFICATION FLASHCARD

☐ ضع علامة في هذا المربع إذا كنت تقرأ أو تتحدث العربية.	1. Arabic
☐ Խնդրում ենք նշում կատարեք այս քառակուսում, եթե խոսում կամ կարդում եք հայերեն:	2. Armenian
☐ যদি আপনি বাংলা পড়েন বা বলেন তা হলে এই বাক্সে দাগ দিন।	3. Bengali
☐ ឈូមបញ្ជាក់ក្នុងប្រអប់នេះ បើអ្នកអាន ឬនិយាយភាសា ខ្មែរ។	4. Cambodian
☐ Motka i kahhon ya yangin ûntûngnu' manaitai pat ûntûngnu' kumentos Chamorro.	5. Chamorro
☐ 如果你能读中文或讲中文，请选择此框。	6. Simplified Chinese
☐ 如果你能讀中文或講中文，請選擇此框。	7. Traditional Chinese
☐ Označite ovaj kvadratić ako čitate ili govorite hrvatski jezik.	8.Croatian
☐ Zaškrtněte tuto kolonku, pokud čtete a hovoříte česky.	9. Czech
☐ Kruis dit vakje aan als u Nederlands kunt lezen of spreken.	10. Dutch
☐ Mark this box if you read or speak English.	11. English
☐ اگر خواندن و نوشتن فارسي بلد هستيد، اين مربع را علامت بزنيد.	12. Farsi

☐ Cocher ici si vous lisez ou parlez le français.	13. French
☐ Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen.	14. German
☐ Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά.	15. Greek
☐ Make kazye sa a si ou li oswa ou pale kreyòl ayisyen.	16. Haitian Creole
☐ अगर आप हिन्दी बोलते या पढ़ सकते हों तो इस बक्स पर चिह्न लगाएँ।	17. Hindi
☐ Kos lub voj no yog koj paub twm thiab hais lus Hmoob.	18. Hmong
☐ Jelölje meg ezt a kockát, ha megérti vagy beszéli a magyar nyelvet.	19. Hungarian
☐ Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano.	20. Ilocano
☐ Marchi questa casella se legge o parla italiano.	21. Italian
☐ 日本語を読んだり、話せる場合はここに印を付けてください。	22. Japanese
☐ 한국어를 읽거나 말할 수 있으면 이 칸에 표시하십시오.	23. Korean
☐ ໃຫ້ໝາຍໃສ່ຊ່ອງນີ້ ຖ້າທ່ານອ່ານຫຼືປາກພາສາລາວ.	24. Laotian
☐ Prosimy o zaznaczenie tego kwadratu, jeżeli posługuje się Pan/Pani językiem polskim.	25. Polish

☐ Assinale este quadrado se você lê ou fala português.	26. Portuguese
☐ Însemnaţi această căsuţă dacă citiţi sau vorbiţi româneşte.	27. Romanian
☐ Пометьте этот квадратик, если вы читаете или говорите по-русски.	28. Russian
☐ Обележите овај квадратић уколико читате или говорите српски језик.	29. Serbian
☐ Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	30. Slovak
☐ Marque esta casilla si lee o habla español.	31. Spanish
☐ Markahan itong kuwadrado kung kayo ay marunong magbasa o magsalita ng Tagalog.	32. Tagalog
☐ ให้กาเครื่องหมายลงในช่องถ้าท่านอ่านหรือพูดภาษาไทย.	33. Thai
☐ Maaka 'i he puha ni kapau 'oku ke lau pe lea fakatonga.	34. Tongan
☐ Відмітьте цю клітинку, якщо ви читаєте або говорите українською мовою.	35. Ukranian
☐ اگر آپ اردو پڑھتے یا بولتے ہیں تو اس خانے میں نشان لگائیں۔	36. Urdu
☐ Xin đánh dấu vào ô này nếu quý vị biết đọc và nói được Việt Ngữ.	37. Vietnamese
☐ באצייכנט דעם קעסטל אויב איר לייענט אדער רעדט אידיש.	38. Yiddish

Please copy this sign and post it in your waiting room to ensure that California Dental Plan members are aware of the Plan's Language Assistance Program.

California DENTAL
A DENTAL HEALTH PLAN
WWW.CALDENTAL.NET • (877)4-DENTAL

Availability of Language Assistance Services

If you, or a member of your family, covered by California Dental Network, cannot speak, read, or write English well enough to understand information received from California Dental Network, or to communicate with your dentist, dental office, or California Dental Network about your dental coverage and treatment, then you may request free language assistance. Call, mail, or fax the plan, or go online at the plan's website.

Disponibilidad de Servicios de Asistencia de Lenguaje

Si usted o un miembro de su familia cubierto por el Plan de California Dental Network no hablan, leen o escriben inglés con suficiente aptitud para entender la información recibida de California Dental Network, o para comunicarse con su dentista, oficina dental o con California Dental Network acerca de su cobertura dental, o de su tratamiento entonces usted puede solicita asistencia en el idioma necesario para comunicarse, sin costo alguno por ese servicio. Llame, escriba por correo o por fax al plan, o visite el sitio de internet del plan.

QUALITY MANAGEMENT

California Dental Network
A DentaQuest company

Policy and Procedure

Policy Name:	**Quality Management Program Direction**	Policy ID:	**PLANCDN-53**
Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
States:	California	Last Review Date:	05/21/2024
Application:	Commercial	Effective Date:	05/22/2024

Quality Management Program Direction

The Plan's Dental Director and administrative staff are responsible for daily implementation of the Quality Assurance Plan and reporting to the Plan's Quality Assurance Committee. The Dental Director (DD) shall hold an active and continuously unrestricted license to practice dentistry in the state of California and serves primarily as the clinical professional responsible for quality of care or clinical issues. The Plan's administrative staff act on non-clinical issues and confer as needed with the DD on clinical and non-clinical activities for the purpose of supporting the activities required by the Quality Assurance Plan.

Quality Assurance Committee (QAC)

California Dental Network's QAC is responsible for reviewing and approving the Plan's QA policies and processes and incorporating such into the Plan's QAP. Through these, the QAC ensures that the services rendered by Plan providers meet current professional standards for quality, appropriateness, safety and effectiveness of dental care. The QAC is further responsible for reviewing all aspects of dental care provided by Plan providers including the structure of care, the process and outcome of care, Member grievances, access to care, utilization of services, verification of credentialing and the resolution of any other QA problem referred to it by the DD or PRC. The QAC meets at least four times a year and reports to the Public Policy Committee (PPC) on findings and recommendations.

The QAC is composed of participating providers, the DD, the QA Coordinator, representatives from the Plan's Provider Relations Department and Grievance Committee (GC), and a health care professional not affiliated with any provider of the Plan. Specialty providers in orthodontics, periodontics, and oral surgery currently participate in QAC activities on a rotating basis.

Peer Review Committee (PRC)

California Dental Network's PRC also provides peer participation and review in the QAP. The PRC functions to ensure that dental care is provided in accordance with the policies and standards of the QAC. Additionally, through the DD, the PRC prepares a summary of findings and recommendations for the QAC. The PRC meets as needed, but not less than quarterly. The PRC committee consists of the Plan Dental Director, and providers who are contracted with the Plan. The PRC Committee membership includes both general dentists and specialists. The PRC reviews issues related to provider credentialing as well as quality issues raised through the grievance process. Although the QAC/PRC meet concurrently, they function independently and separate minutes of each group are maintained.

Credentialing Committee (CC)

The Credentials Committee is a standing committee and is responsible for administering the Credentialing Plan on behalf of CDN, subject to review by the Quality Assurance Committee. The Credentials Committee convenes at least once per month to review all dental Providers subject to initial credentialing,

recredentialing, Providers reapplying to the network and all Provider credentialing appeals. Any adverse credentialing decisions are referred to the Quality Assurance Committee for final decision. In addition, the Credentials Committee reviews any Medicare/Medicaid and/or state licensing actions against any network Providers that occur between recredentialing cycles. The Credentials Committee Members represent a range of participating practitioners within CDN's network, and sign an affirmative statement to make decisions in a nondiscriminatory manner. The Credentials Committee's determinations are reflected in the Credentials Committee minutes. The minutes reflect the discussion of the applicants' files. The Credentials Committee minutes are maintained electronically in a secure folder.

The Dental Director (or their designee) chairs the Credentials Committee. Members include not less than two (2) dentists, the local Dental Consultant(s), where available, and available credentialing Subject Matter Experts. Two dentists shall constitute a quorum. A dental hygienist may also serve as a voting Member of the committee."

Grievance Committee (GC)

California Dental Network's GC reviews Member grievances and coordinates provider responses and record submissions. After consideration of the relevant evidence, it reaches a consensus resolution. The resolution is communicated in writing to the interested parties. If insufficient information is available to arrive at a determination, the GC requests additional documentation or clinical consultation and evaluation by third party dentists. The GC logs information and provides timely reports regarding QA issues that arise during the grievance process. These are made to the DD and the QAC.

Public Policy Committee (PPC)

California Dental Network's PPC provides a forum for subscribers and enrollees to participate in establishing the public policy of the Plan as defined in Section 1369 of the Knox-Keene Health Care Service Plan Act of 1975. The PPC will conduct formal recorded meetings on a quarterly basis to review design and ongoing implementation and effectiveness of the quality care review system. The recommendations and reports of the public policy committee will be regularly and timely reported to the California Dental Network Board of Directors. The Board will act upon such recommendations, and such actions will be recorded in the Board's minutes.

The QAC will provide reports to the PPC which will include findings and actions taken, as well as a result of the QAP. There will be a minimum of five persons on the PPC which will include a member of the Board of Directors and a Plan dentist chosen by the board. All others will be Plan subscribers and/or enrollees who are not Plan employees, Plan-contracted dentists, health care providers, subcontractors to the Plan, group brokers or persons financially interested in the Plan, or persons with a financial interest in the Plan.

California Dental Network will try to assure that Members will serve a minimum one year term and that terms will overlap to provide continuity and experience in representation.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

QUALITY MANAGEMENT

California Dental Network
A DentaQuest company

Policy and Procedure

Policy Name:	**Quality Management Continuity and Coordination of Care**	Policy ID:	**PLANCDN-54**
Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
States:	California	Last Review Date:	05/21/2024
Application:	Commercial	Effective Date:	05/22/2024

Quality Management Continuity and Coordination of Care

The Plan provides for basic dental services in a manner that provides coordination of care. The Plan offers a panel of providers from which the enrollee may select a primary care provider who will be responsible for coordination of the member's healthcare. The Plan encourages each enrollee to choose a primary care dentist. Brokers are instructed to encourage group enrollees to select a primary care dentist at the time of enrollment New individual Plan enrollees are encouraged to list the name of their chosen provider on their application. The Plan provides lists of providers to prospective enrollees from which to choose; additionally, the Plan's website has a current list of providers. To ensure timely access to care those new enrollees who have not selected a primary care dentist at the time of enrollment are sent membership cards that instruct the enrollee to select a primary care dentist and contact the Plan for assignment to the chosen provider. Ninety days after enrollment those enrollees who have still not selected a primary care dentist are typically assigned to one by the Plan, based on residence zip code, and a letter is sent informing the enrollee of the assignment and how to contact the Plan should they wish to change assignment.

The Plan has a network of dental specialists in the fields of orthodontics, periodontics, endodontics, pedodontics, and oral surgery, that ensures timely, reasonable, and confidential access to specialty care when in the opinion of the primary care dentist, such care is necessary. Section 3: Utilization Management describes how the specialty referral and coordination of care process functions. Primary care dentists are informed of the Plan's specialty referral policies and procedures in the provider manual "Administrative Guidelines for general Dentists", which is given to each primary care dentist upon initially contracting with the Plan.

The Plan monitors evidence of coordination of care during the periodic Quality Assurance Assessments as well as through Member grievance, Member satisfaction surveys, and Specialty Referral Tracking; and address any identified deficiencies.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description

8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

QUALITY MANGEMENT	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Quality Management Preventive Health Care Services**	Policy ID:	**PLANCDN-55**
	Approved By:	Quality Assurance Committee	Last Revision Date:	8/18/2021
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Quality Management Preventive Health Care Services

The Plan has written procedures for the provision of dental services, including preventive care. The procedures are communicated to providers in the Quality Assurance section of the Plan's provider manual "Administrative Guidelines for General Dentists". (See Section 1: Access and Availability, AA006 Enrollee Health). These Procedures include provisions for periodic oral examinations and cleanings as well as the provision of oral health education.

The Plan communicates it recommendations for preventive care to Members in a brochure that is provided to enrollees at the time of enrollment and annually thereafter. This brochure provides information about the importance of healthy behaviors, how to access information about dental health topics, including prevention, and how to use Plan dental services effectively.

The Plan ensures that preventive services are provided to Members. The Plan tracks the provision of preventive services through Utilization data, Provider Quality Assurance Assessments, Access Monitoring, Member Satisfaction surveys, and Grievance tracking. The Plan address any identified deficiencies either at the individual provider level or the provider network level.

Statutory/Regulatory Citations:

- CA Health and Safety Code section 1300.70

Revision History

Date:	Description
8/18/2021	Conversion to revised policy and procedure format and naming convention.
11/15/2022	Annual Review

GUIDELINES FOR GENERAL DENTISTS

Language Assistance Program

California Dental Network

A DentaQuest company

LANGUAGE ASSISTANCE PROGRAM	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Language Assistance LEP Assessment**	Policy ID:	**PLANCDN-60**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

LEP Assessment

PURPOSE

To establish the California Dental Network Language Assistance Services and Nondiscrimination Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

California Dental Network (CDN) has policies and procedures for the provision of language Assistance to Limited English Proficient (LEP) Enrollees, to alleviate language barriers to obtaining Plan covered dental services.

SCOPE

This Policy applies to all employees, both full and part-time, interns, contractors, vendors and any other entity or individual who sells, services or administers products and activities for California Dental Network (CDN) commercial products offered both on and off the Covered California Marketplace.

POLICY

Initial Assessment

The Plan has determined the non-English Languages likely to be encountered among its enrollee population.

In 2008, the Plan performed an initial enrollee assessment of its membership to determine the enrollee language needs and enrollee demographic profile of Plan enrollees. The Plan accessed the United States Census Bureau website and downloaded data from the 2003-2007 Census for each of the 24 counties that have more than 100 enrollees. The percent of total county population that speak each of the 30 language categories determined by the US Census is multiplied by the number of Plan subscribers in each county to determine the number of individuals in each county that potentially speak each of these languages (these include: English, Spanish, other Indo-European language, Asian and pacific islander language, other languages). The total number of the Plan population that speaks each of the five languages was determined by adding the county data. Finally, the percent of each language represented in the Plan membership was calculated.

The Plan determined the non-English languages likely to be encountered among its enrollee population (at least .5% of Plan enrollment) are: English, Spanish, Chinese, Vietnamese, and various dialects spoken in India. Currently the Plan's two threshold languages, spoken by at least 5% or 3000 of the Plan's enrollees, are English and Spanish.

Any language representing 3000 or more individual enrollees or five percent or more of CDN's member

population (whichever was less) is considered a threshold language for purposes of the

initial member population assessment. Using the 1.34 enrollee to subscriber multiplier, the Plan determined that 5% of the Plan's enrollees equaled 1593 enrollees (or 1193 subscribers) in 2008. The final tally determined that the Plan's two threshold languages are English and Spanish.

The Plan complied with the Department of Managed Health Care's (DMHC'S) requirement to survey enrollees by distributing, on June 27, 2008, the disclosure required by the third sentence of 1300.67.04(c) (1) (B) to all subscribers, including all individual subscribers under group contracts. (See Attachment 1)

The Plan records any information obtained from responding enrollees, or providers in the Plan's database with the enrollees other enrollment information, in a manner that preserves the confidentiality of personal information; and will disclose the information to the DMHC on request for regulatory purposes, and to contracting providers on request for lawful purposes, including language assistance and quality improvement purposes.

Triennial Enrollee Reassessment

The Plan performs a triennial enrollee assessment of its membership to monitor the enrollee language needs and enrollee demographic profile of Plan enrollees. The Plan accesses the United States Census Bureau website and downloads the most recently available data for each of the counties that have more than 100 enrollees. The Plan uses America Community Survey Data from the US Census Bureau for the Language Assessment and the decennial US Census Data for the Race and Ethnicity Data.

Race and Ethnicity Assessment

The percent of total county that population identifying as one of the each of the seven race categories listed by the US Census (see Attachment 2) is multiplied by the current number of Plan subscribers in each county to determine the number of individuals in each county that potentially identify as each of the seven race categories. The total number of the Plan population that identify as each of the seven race categories is calculated by adding the county data. Finally, the percent of each racial category represented in the Plan membership is calculated.

The percent of total county that population identifying as "Hispanic or Latino", or "Not Hispanic or Latino", the two ethnicity categories listed by the US is multiplied by the number of Plan subscribers in each county to determine the number of individuals in each county that potentially identify as either of the ethnicity categories. The total number of the Plan population that identify as either of the two ethnicity categories is calculated by adding the county data.
Finally, the percent of each ethnicity category represented in the Plan membership is calculated.

Language Assessment

The percent of total county population that speak each of the 30 language categories listed by the US Census (see Attachment 2) is multiplied by the number of Plan subscribers in each county to determine the number of individuals in each county that potentially speak each of the listed languages. The total number of the Plan population that speaks each of the languages is determined by adding the county data. Finally, the percent of each language represented in the Plan membership is calculated.

The Plan determines the non-English languages likely to be encountered among its enrollee population to be those representing at least .5% of Plan enrollment. Any language representing 3000 or more individual enrollees or five percent or more of CDN's member population (whichever is less) is considered a threshold language for purposes of the triennial member population assessment.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.67.04 Language Assistance Programs

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review

LANGUAGE ASSISTANCE PROGRAM	California Dental Network A DentaQuest company		
	Policy and Procedure		
	Policy Name:	**Language Assistance Compliance Monitoring**	Policy ID:	**PLANCDN-61**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Language Assistance Compliance Monitoring

PURPOSE

To establish the California Dental Network Language Assistance Services and Nondiscrimination Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

California Dental Network (CDN) has policies and procedures for the provision of language Assistance to Limited English Proficient (LEP) Enrollees, to alleviate language barriers to obtaining Plan covered dental services.

SCOPE

This Policy applies to all employees, both full and part-time, interns, contractors, vendors and any other entity or individual who sells, services or administers products and activities for California Dental Network (CDN) commercial products offered both on and off the Covered California Marketplace.

POLICY

- The Plan monitors, and modifies as necessary, the Plan's Language Assistance Program (including any portions delegated to other entities) to ensure compliance with regulations. The Plan periodically queries its providers; reviews enrollee and provider grievances; and solicits feedback from enrollees receiving services from the on-call agencies which it contracts with to provide translation and interpretation services. The Plan compiles the information obtained, analyzes and evaluates the collected information for compliance with Section 1367.04 and Rule 1300.64. The Plan then formulates and implements corrective action plans as necessary to assure ongoing compliance. The Plan reports on its compliance to the Plan's Quality Assurance Committee and Public Policy Committee on a quarterly basis.

- The Plan has ensured that all contracts with providers issued, amended, delivered, or renewed on or after January 1, 2009 are in compliance with the Plan's LAP, and require the provider to cooperate with the Plan by providing any information necessary to assess compliance.

- The Plan does not require the contracting provider to accept the financial risk of providing language assistance as a condition of accepting the provider contract.

- The Plan ensures that any contracts with agencies delegated with the responsibility for providing translating or interpreting services, or LAP training to Plan Staff shall clearly specify the respective obligation of the parties, and the Plan's method for monitoring proper performance.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.67.04 Language Assistance Programs

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review

LANGUAGE ASSISTANCE PROGRAM	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Language Assistance Staff Training**	Policy ID:	**PLANCDN-62**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

\Language Assistance Staff Training

PURPOSE

To establish the California Dental Network Language Assistance Services and Nondiscrimination Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

California Dental Network (CDN) has policies and procedures for the provision of language Assistance to Limited English Proficient (LEP) Enrollees, to alleviate language barriers to obtaining Plan covered dental services.

SCOPE

This Policy applies to all employees, both full and part-time, interns, contractors, vendors and any other entity or individual who sells, services or administers products and activities for California Dental Network (CDN) commercial products offered both on and off the Covered California Marketplace.

POLICY

All Plan staff shall receive training, as part of their new employee orientation and annually thereafter in:

- The Plan's policies and procedures for language assistance
- Working effectively with LEP enrollees
- Working effectively with interpreters in-person, over the phone, and in any other media (such as video) as may be applicable
- Understanding the cultural diversity of the Plan's enrollee population, and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.67.04 Language Assistance Programs

Revision History

Date:	Description
08/24/2021	Approval and Adoption

07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review

LANGUAGE ASSISTANCE PROGRAM	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Language Assistance Services and Nondiscrimination**	Policy ID:	**PLANCDN-63**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Language Assistance Services and Nondiscrimination

PURPOSE

To establish the California Dental Network Language Assistance Services and Nondiscrimination Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

California Dental Network (CDN) has policies and procedures for the provision of language Assistance to Limited English Proficient (LEP) Enrollees, to alleviate language barriers to obtaining Plan covered dental services.

SCOPE

This Policy applies to all employees, both full and part-time, interns, contractors, vendors and any other entity or individual who sells, services or administers products and activities for California Dental Network (CDN) commercial products offered both on and off the Covered California Marketplace.

POLICY

Points of Contact:

The Plan has identified Points of Contact (instances in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts).

For the initial evaluation the Plan reviewed its own internal, administrative procedures, grievance and member service information; interviewed providers and brokers; and held internal discussions with its quality assurance committee members.

The following have been identified as the Plan's Points of Contact:

- Provider level: provider offices for appointment scheduling (face to face and over the phone), completion of new patient intake forms, diagnosis, treatment planning and financial arrangements, consents to treatment, treatment, aftercare instructions, coordination of care with specialist offices, and grievances and complaints; and

- Plan-level: calls, on-line, and in-person Member Services contacts regarding enrollment, premium payments, eligibility and benefits, selecting a provider office, referral processing, claims payment, assistance in communicating with the provider office, and grievances and complaints; and

- Broker level: enrollment, questions of coverage and benefits.

The Plan shall, on an ongoing basis, review its processes to determine Points of Contact where the need for language assistance services could be reasonably anticipated.

The Plan determined that specific Plan resources needed to provide effective language assistance services to the Plan's enrollees include the following:

- Bilingual Member Services staff at the Plan for all identified threshold languages - The Plan has sufficient Member Services staff able to speak the identified language (Spanish).

- IT staff - A review of the Plan's data storage system determined that existing IT staff could handle the changes to the database required to record and communicate the needed information.

- Broker assistance - The Plan has added a bilingual staff person to assist the brokers with marketing and enrollment.

Interpretation and translation services - The Plan has contracted with agencies to provide interpretation and translation services to Members, on an on-call basis. These agencies have been selected for their experience in medical/dental specific services, and have demonstrated that they have had education in interpreting ethics, conduct, and confidentiality. These interpreters and translators are available by phone or online to assist the Plan at all points of contact.

The Plan does not charge enrollees for language assistance services. The Plan informs enrollees of the availability of free language assistance services and how enrollees can access those services. The notification of availability of free language assistance services is available on the Plan's website, on the Plan's online directory, in the Plan's EOC, on all Plan brochures, on all vital documents, and included in all correspondence with members in which action may need to be taken by the member.

Initially, the Plan distributed to all subscribers, including all individual subscribers under group contracts, a disclosure explaining in English and the Plan's threshold languages the availability of free language assistance services, and how to inform the Plan and the relevant providers regarding the preferred and spoken languages of the subscriber and other enrollees under the subscriber contract.

This disclosure is distributed at the time of enrollment and at annual renewals, in the Plan's brochure that explains how to use the Plan. For LEP enrollees who do not speak threshold languages the Plan will contact its contracting interpreting service and enlist its assistance in explaining the availability of no cost translation and interpretation services to the enrollee.

The Plan attempts to identify a Limited English Proficient (LEP) enrollee at the Plan level from existing information in the Plan's database; for those enrollees who have not provided this information the following contact points and processes have been determined:

At the Plan level, Member services staff use the phone system, which offers, in the Plan's threshold languages, an extension number to speak with a qualified bilingual Member Services person.

Additionally, Member Services staff are trained to identify callers who may be LEP. Those enrollees identified as possibly being LEP are asked the following 2 questions, which were developed by the U.S. Census:

- Do you speak a language other than English in your home? A yes answer will constitute an LEP enrollee;

- How well do you speak English? Any answer other than "very well" assigns the enrollee to the LEP group;

LEP enrollees are also identified by their written communication with the Plan. Written communication that is in a language other than English, or appear to lack proficiency, will initially be identified as from an LEP enrollee.

At the provider level, providers will be advised of their responsibility to identify LEP individuals, preferably at their initial contact with the office. This would include enrollees who have previously brought in their own translators.

At the broker level, enrollees who are having trouble filling out the enrollment forms or request forms in other than the threshold languages will be identified as LEP individuals.

Once they are identified as LEP, enrollees are informed at all points of contact, either verbally or in writing, that interpretation services are available at no cost, and the Plan will facilitate individual enrollee access to interpretation services.

The Plan includes the notice explaining the availability of free language assistance services with vital documents, enrollment materials, and correspondence regarding new or renewed enrollment. The notice is either incorporated in the text or attached to the material.

The Plan includes notices regarding free language assistance services with brochures, newsletters, outreach and marketing materials, and other materials routinely disseminated to enrollees. The notice is either incorporated in the text or attached to the material.

The Plan provides all LEP enrollees information regarding the rights to file a grievance and seek Independent Medical Review (IMR) in threshold languages and through oral interpretation as follows:

- Grievance forms and procedures are translated into threshold languages and are made available directly to enrollees and to contracted providers for distribution to enrollees upon request.
- Grievance forms and procedures translated into threshold languages are mailed or faxed by Member Services to enrollees and providers, upon request.
- The forms and procedures translated into threshold languages are available online.
- The forms and procedures translated into threshold languages are included in the Provider manual.
- The provider manual advises contracted providers that complaint, grievance, and IMR information in non-English languages is available at the Department's web site www.dmhc.ca.gov.

The Plan informs its contracted providers of the standards and mechanisms for providing free language assistance services to enrollees and the Plan will ensure that LEP enrollee language needs information collected by the Plan is available to contracted providers.

The Plan communicates the language assistance program requirements to contracted providers as follows:

- Initially, and periodically thereafter, through the Plan's newsletter that is sent to the provider with the monthly eligibility lists.

- The requirements will are communicated in the Provider manual.

- The information regarding LEP enrollees' language assistance needs for a routine situation is communicated to providers on the eligibility rosters sent monthly to each provider. The provider may also access the eligibility roster (which is updated weekly) online.

- The information regarding LEP enrollees' language assistance needs for an emergency or non- routine situation is communicated by telephone to the provider.

Vital Documents

The Plan has identified the following documents as standardized and enrollee-specific vital documents that must be translated:

- Applications

- Plan consent forms (any form by which an enrollee consents to any action by the Plan) -Grievance form

- Letters containing eligibility and participation criteria, notices pertaining to the denial, reduction, modification, or termination of services and benefits and the right to file a grievance or appeal, which consist of the following Plan documents:
    - Grievance form
    - Acknowledgement of receipt of grievance Denial of Specialty Referral Request Member ID card
    - Payment past-due notice (including termination of services and benefits)

- Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees

- The Plan's Explanation of Benefits (or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee), which consists of the following Plan documents:
    - Specialty referral approval form Claim form/explanation of benefits
    - Credit card company denial of payment notice

- The Plan's disclosure of benefits, limitations and exclusions distributed in a uniform matrix format which consists of the following Plan documents:
    - Uniform matrix for each benefit plan
    - Plan's Combined Evidence of Coverage and Disclosure form

The standard for making these documents available to enrollees is that the Plan will attach, or incorporate in all vital documents, a notice, in the Plan's threshold languages, advising of the availability of free translation and interpretation services.

Upon request by an enrollee for a translated document, it will be sent within 21 days.

The Plan arranges for interpretation of vital documents in accordance with the Plan's timeframes, which are:

- Emergency requests – within 24 hours
- Urgent requests – within 72 hours
- Routine requests – within 2 weeks

Upon request, the Plan arranges for the provision of translated vital documents to enrollees at no charge. The Plan may use Plan employees or contract with agencies to provide translations of vital documents on an on-call basis.

The translated documents may be provided by mail, phone, fax or internet.

Plan employees and outside contracting agencies will be selected for their experience in medical/dental specific services and must demonstrate that they have the ability to provide translations that will meet the same standards as English language versions of those documents.

The Plan will require that each document is translated by two different translators and compared, or that a single translation is reviewed by two different translators, to check for accuracy, tone, and appropriate use of the language.

On an annual basis, the Plan will review the accuracy of the agencies contracted to provide translated Plan documents by submitting translated documents from one agency for back- translation by the second organization the Plan has contracted with for translation services. Vital documents that have been translated by the Plan's contracted agencies are reviewed by bilingual plan staff to ensure that they meet the standards of the English versions.

The Plan shall provide non-standardized vital documents containing enrollee specific information in English and will include a notice, in the Plan's threshold languages, of the availability of translation and interpretation services upon request. The Plan includes the required notice (or translated versions of the documents) with all vital documents, enrollment materials, and correspondence confirming new or renewed enrollment, except when documents are sent in enrollee's preferred language. The notice states the following:

> When you ask, CDN will provide no charge interpretation or translation of this document into your preferred language. When you request a translation, you will receive it within 21 days of the request. When you request interpretation, CDN will arrange for interpretation services within 24 hours for emergency requests; within 72 hours for urgent requests; and within 2 weeks for routine requests. To request translation or interpretation, contact Member Services by mail, phone, fax, or online, as listed below:
>
> California Dental Network
> 23291 Mill Creek Suite 100 Laguna Hills, CA 92653
> Telephone: 949-830-1600 Toll-Free: 877-433-6825 (TTY 711) Fax: 949-8360-1655
> www.caldental.net
>
> Cuando lo solicite, CDN proporcionará servicios de interpretación o traducción de este documento a su idioma preferido sin costo para usted. Cuando solicite una traducción, la recibirá dentro de los 21 días posteriores a la solicitud. Cuando solicite interpretación, CDN procurara los servicios de interpretación en un plazo de 24 horas para solicitudes de emergencia, un plazo de 72 horas para solicitudes urgentes y un plazo de 2 semanas en solicitudes de rutina. Para solicitar servicios de traducción o interpretación, comuníquese con Servicios para Miembros por correo, teléfono, fax o en línea, como se indica a continuación:
>
> California Dental Network
> 23291 Mill Creek Suite 100 Laguna Hills, CA 92653
> Teléfono: 949–830-1600 Sin costo alguno: 877-433-6825 (TTY 711) Fax: 949-830-1655
> www.caldental.net

The Plan ensures that any requested translations are provided in accordance with Section 1367.04.

For translations the Plan maintains a translation log which will include the date the request was received at the Plan and the date the translation was sent to the enrollee. The Plan's Grievance coordinator will check the status of each translation on a weekly basis, and follow up as needed, to ensure that the translation is completed, reviewed and sent within the Plan's translation timeframes, which are in accordance with Section 1367.04.

The Plan has developed processes and standards for providing individual enrollees with free interpretation services at all points contact.

In the event that interpreters are not available at the provider office, the Plan has contracted with agencies to

provide interpretation services, on an on-call basis, to explain to LEP enrollees the information contained in Plan-produced documents that are not in the enrollee's language.

Interpretation services will be offered to all LEP enrollees for free at all points of contact, even if the enrollee is accompanied by a family member or friend who can interpret.

The offer of an interpreter, and the enrollee's denial, if declined, will be included in the medical record or health plan file, as applicable:

- At the Plan level, Member Services staff will record this information with other member- specific information on the Plan's database.

- Providers will be advised by newsletter and in the Plan's provider manual that the offer and refusal of an interpreter must be recorded in the enrollee's dental record.

The Plan makes arrangements to provide or arrange for timely, free interpretation services to LEP enrollees at all points of contact:

- The Plan maintains a listing which is updated quarterly of the languages spoken at each provider location. Whenever possible LEP enrollees are encouraged and assisted to select a provider location where their preferred language is spoken by the staff.
- When a provider first contracts with the Plan he or she is asked to list any languages other than English spoken at that location, and to complete a language capability disclosure form that attests to the competency of the staff to provide accurate interpretations of dental terminology and concepts. This information is recorded in the Plan's database and used to update the Plan's provider lists. Quarterly, providers are requested to update current language availability.

At provider locations, when a provider determines that interpreting services are needed which cannot be provided by the provider's staff, the provider shall contact the Plan. The Member Services staff person arranges for interpretation through the Plan's list of on-call interpreting agencies, in a timely fashion (appropriate for the situation in which language assistance is needed and in accordance with the Plan's standards for timeliness, and in such a manner as to not result in the effective denial of service, benefit, or right at issue), and at no charge to the Member or the provider. Brokers who require interpretation or translation services will be directed to advise their contact at the Plan, who will coordinate such services through Member Services.

The Plan's standard for interpretation timeliness shall be:
- Emergency care - 24hrs
- Urgent care - 72hrs
- Routine health care - 2 weeks

Coordinating interpretation services with appointment scheduling – the Plan requires that providers will, within reason, cooperate with interpreters to coordinate appointment scheduling with the availability of the interpreter.

The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact include:

- Plan and provider staff who are bilingual and trained and competent in the skill of interpreting, including, on a volunteer basis, staff from other provider offices who have signed a language capability disclosure form that attests to the competency of the staff to provide accurate interpretations of dental terminology and concepts.

- Interpretation provided by outside agencies that the Plan has contracted with.

These services may be available in person, or by telephone, videoconferencing, or other telecommunications mode.

Proficiency Standards:

The Plan's proficiency standards for the individuals providing translation and interpretation services to enrollees are as follows:

- A documented and demonstrated proficiency in both English and the other language.
- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems.
- Education and training in interpreting ethics, conduct, and confidentiality.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.67.04 Language Assistance Programs

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review
9/27/2022	Updates based on DMHC Preliminary Survey Report

Please copy this sign and post it in your waiting room to ensure that California Dental Plan members are aware of the Plan's Language Assistance Program.

California DENTAL
A DENTAL HEALTH PLAN
WWW.CALDENTAL.NET • (877)4-DENTAL

Availability of Language Assistance Services

If you, or a member of your family, covered by California Dental Network, cannot speak, read, or write English well enough to understand information received from California Dental Network, or to communicate with your dentist, dental office, or California Dental Network about your dental coverage and treatment, then you may request free language assistance. Call, mail, or fax the plan, or go online at the plan's website.

Disponibilidad de Servicios de Asistencia de Lenguaje

Si usted o un miembro de su familia cubierto por el Plan de California Dental Network no hablan, leen o escriben inglés con suficiente aptitud para entender la información recibida de California Dental Network, o para comunicarse con su dentista, oficina dental o con California Dental Network acerca de su cobertura dental, o de su tratamiento entonces usted puede solicita asistencia en el idioma necesario para comunicarse, sin costo alguno por ese servicio. Llame, escriba por correo o por fax al plan, o visite el sitio de internet del plan.

Please use these Language Identification Flashcards to assist CDN members in communicating with you and your office staff. If a Plan member requests translation services, please contact the Plan at 1-800-4-DENTAL.

LANGUAGE IDENTIFICATION FLASHCARD

☐ ضع علامة في هذا المربع إذا كنت تقرأ أو تتحدث العربية.	1. Arabic
☐ Խնդրում ենք նշում կատարեք այս քառակուսում, եթե խոսում կամ կարդում եք հայերեն:	2. Armenian
☐ যদি আপনি বাংলা পড়েন বা বলেন তা হলে এই বাক্সে দাগ দিন।	3. Bengali
☐ ឈូមបញ្ជាក់ក្នុងប្រអប់នេះ បើអ្នកអាន ឬនិយាយភាសា ខ្មែរ។	4. Cambodian
☐ Motka i kahhon ya yangin ûntûngnu' manaitai pat ûntûngnu' kumentos Chamorro.	5. Chamorro
☐ 如果你能读中文或讲中文，请选择此框。	6. Simplified Chinese
☐ 如果你能讀中文或講中文，請選擇此框。	7. Traditional Chinese
☐ Označite ovaj kvadratić ako čitate ili govorite hrvatski jezik.	8.Croatian
☐ Zaškrtněte tuto kolonku, pokud čtete a hovoříte česky.	9. Czech
☐ Kruis dit vakje aan als u Nederlands kunt lezen of spreken.	10. Dutch
☐ Mark this box if you read or speak English.	11. English
☐ اگر خواندن و نوشتن فارسي بلد هستيد، اين مربع را علامت بزنيد.	12. Farsi

☐ Cocher ici si vous lisez ou parlez le français.	13. French
☐ Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen.	14. German
☐ Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά.	15. Greek
☐ Make kazye sa a si ou li oswa ou pale kreyòl ayisyen.	16. Haitian Creole
☐ अगर आप हिन्दी बोलते या पढ़ सकते हों तो इस बक्स पर चिह्न लगाएँ।	17. Hindi
☐ Kos lub voj no yog koj paub twm thiab hais lus Hmoob.	18. Hmong
☐ Jelölje meg ezt a kockát, ha megérti vagy beszéli a magyar nyelvet.	19. Hungarian
☐ Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano.	20. Ilocano
☐ Marchi questa casella se legge o parla italiano.	21. Italian
☐ 日本語を読んだり、話せる場合はここに印を付けてください。	22. Japanese
☐ 한국어를 읽거나 말할 수 있으면 이 칸에 표시하십시오.	23. Korean
☐ ໃຫ້ໝາຍໃສ່ຊ່ອງນີ້ ຖ້າທ່ານອ່ານຫຼືປາກພາສາລາວ.	24. Laotian
☐ Prosimy o zaznaczenie tego kwadratu, jeżeli posługuje się Pan/Pani językiem polskim.	25. Polish

☐ Assinale este quadrado se você lê ou fala português.	26. Portuguese
☐ Însemnaţi această căsuţă dacă citiţi sau vorbiţi româneşte.	27. Romanian
☐ Пометьте этот квадратик, если вы читаете или говорите по-русски.	28. Russian
☐ Обележите овај квадратић уколико читате или говорите српски језик.	29. Serbian
☐ Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	30. Slovak
☐ Marque esta casilla si lee o habla español.	31. Spanish
☐ Markahan itong kuwadrado kung kayo ay marunong magbasa o magsalita ng Tagalog.	32. Tagalog
☐ ให้กาเครื่องหมายลงในช่องถ้าท่านอ่านหรือพูดภาษาไทย.	33. Thai
☐ Maaka 'i he puha ni kapau 'oku ke lau pe lea fakatonga.	34. Tongan
☐ Відмітьте цю клітинку, якщо ви читаєте або говорите українською мовою.	35. Ukranian
☐ اگر آپ اردو پڑھتے یا بولتے ہیں تو اس خانے میں نشان لگائیں۔	36. Urdu
☐ Xin đánh dấu vào ô này nếu quý vị biết đọc và nói được Việt Ngữ.	37. Vietnamese
☐ באצייכנט דעם קעסטל אויב איר לייענט אדער רעדט אידיש.	38. Yiddish

GUIDELINES FOR GENERAL DENTISTS

Appointments

California Dental Network

A DentaQuest company

Access and Availability	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Access and Availability Appointment Availability**	Policy ID:	**PLANCDN-42**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Access and Availability Appointment Availability

Purpose

To establish the California Dental Network Utilization Management policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable. The Plan's standard for the number and distribution of General Dentists and Specialists assures that the locations of care facilities are within reasonable proximity to the business or personal residence of enrollees and that there are sufficient providers to meet the needs of enrollees. Additionally, the Plan maintains standards for hours of operation, after-hours access, and waiting times to assure timely access to care.

Scope:

This Policy applies to all employees, both full and part-time, interns, contractors, vendors and any other entity or individual who sells, services or administers products and activities for California Dental Network (CDN) commercial products offered both on and off the Covered California Marketplace.

Policy

California Dental Network's Quality of Care process sets forth the following protocols for patient accessibility, which will be monitored for compliance:

Timely Access Standards

The usual waiting period for an initial or routine care appointment with a dentist shall not exceed 36 days. Appointments for preventive care shall be available in forty days. Specialist care shall also be available in 36 days. Urgently needed general or specialty care services shall be provided as soon as medically indicated, but in all cases within 72 hours.

If an appointment is not kept, the dental office will contact the Member by telephone to reschedule the appointment. If the Member cannot be reached by telephone, the dental office will notify the Member by post card to contact the dental office to reschedule the appointment. The responsible California Dental Network staff member for provider relations will monitor provider accessibility through a review of problems relative to telephone accessibility, appointment ease and waiting time, etc. Additional complaints or suggestions from Members and providers will be used in assessing accessibility of services.

Emergency Availability

California Dental Network's Dental Services Agreement for General Dentists obligates contracted panel providers to provide necessary emergency service 24-hours a day, seven days a week. This required treatment is limited to emergency care. Providers are to attend to immediate emergencies and can schedule follow-up appointments for further definitive treatment. Failure to provide adequate emergency care can lead to corrective action by the Plan, including a reduction of a provider's capitation payment to cover any emergency charges incurred by a Member.

Each provider shall have and be able to demonstrate a functional system for handling after- hours emergency telephone calls. Contracted providers are required to employ an answering service or a telephone answering machine during non-business hours, which provides instructions regarding how members may obtain urgent or emergency care, including how to contact another provider who has agreed to be on-call to triage or screen by phone or, if needed, to deliver urgent or emergency care.

In an emergency, the Plan advises and encourages Members to first contact their panel provider for dental emergencies. The Plan also maintains a toll-free telephone number to assist its Members. A Customer Service Department representative aids any Member who calls during regular Plan business hours. If the Member is experiencing a dental emergency and cannot contact his panel provider, the representative first attempts to help the Member communicate with his panel office. If the panel provider cannot be reached, the representative finds another contracted dentist to provide emergency treatment. If this also cannot be arranged, then the Member is authorized to seek emergency care by a dentist of their choice. Callers to the Plan after hours are provided pre-recorded instructions on how to access emergency care.

Any indication of failure of a panel provider to render adequate emergency care is reported to the Provider Relations Department and Dental Director. This leads to corrective action through the QA system.

Waiting Times
Waiting times shall not exceed one-half hour for scheduled appointments.

Description of System for Monitoring Accessibility

The discovery of problems respective to accessibility within the offices shall be accomplished through enrollee satisfaction surveys, random telephone accessibility surveys, monitoring of provider appointment books, and the grievance system. Validation of afterhours and emergency access and appointment availability survey results is done in the course of periodic facility audits and through routine audits conducted by Plan staff. The Plan also tracks access related Member complaints, grievances, contacts, and transfer requests. This allows the Plan to further identify offices requiring investigation. Access reports are also used by the Provider Relations Department to identify key areas for the recruitment of new providers.

The annual enrollee satisfaction survey will be randomly sent to enrollees of the plan. The information received back will be tallied and reviewed by the Public Policy Committee, Quality Assurance Committee, and the Board of Directors. The survey requests information in the following areas:

- Convenience of dental appointments.
- Care and attitude of dentist and front office staff.
- Quality of dental work performed.
- Satisfaction of overall plan.

Provider accessibility shall also be monitored through a review of grievances filed by subscribers and enrollees and complaints lodged by providers. Grievance reports are discussed at the Quality Assurance Committee meetings. Any action, as necessary will be forwarded to the appropriate plan staff.

Access / Appointment Availability

If a patient can take any available appointment, the first appointment currently available should be within California Dental Network's standards for appointment availability, which are as follows:

- Thirty-six business days for an initial non-emergency appointment with a general dentist.
- Thirty-six business days for a routine non-emergency appointment with a general dentist.
- Forty business days for appointments for preventive care.
- Thirty-six business days for an non-emergency specialist appointment

- 24-hour availability for emergency care and doctor available.
- A working recall system.
- Urgent appointments offered within 72 hours.

If the Plan's access and availability surveys reveal that the Plan is not meeting its standards across the provider network, then the Plan develops a corrective action and re-measures to ensure that standards are met.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.68 Grievance System

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review
10/10/2022	Updates based on Plan Management team discussion.

GUIDELINES FOR GENERAL DENTISTS

Complaints, Grievances, and Appeals

California Dental Network

A DentaQuest company

PLAN OPERATIONS	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**Complaints, Grievance and Appeals Program Description**	Policy ID:	**PLANCDN-30**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Complaints, Grievance and Appeals Program Description

Purpose

To establish the California Dental Network Complaints, Grievances and Appeals Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

A grievance is defined as a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a member or the member's representative. In cases where CDN is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. The member does not need to intend to submit a grievance—the issue becomes a grievance the moment the member expresses dissatisfaction regarding the Plan or provider.

This policy aims to receive and resolve complaints, grievances and appeals in a manner that is fair, efficient and confidential and takes into account the needs, rights and responsibilities of the involved parties.

Policy

The Plan has established a complaints, grievances and appeals (CGA) system that ensures adequate consideration of enrollee grievances and rectification when appropriate. The Plan's Dental Director shall have primary responsibility for the Plan's CGA system and shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The Plan's Director of Operations shall be responsible for the day-to-day operation of the grievance system, including formal grievances and 24-hour exempt (telephone) grievances.

California Dental Network will communicate in writing to its Members telephone numbers, locations and relevant procedures for the filing of complaints and grievance through the Combined Evidence of Coverage and Disclosure Form, which will be available online at the Plan website as well as distributed to Members along with their membership identification card at enrollment and subsequent annual renewals. A toll-free number will be available for the filing of complaints or grievances, which is accessible from all of the California Dental Network's service areas. Grievance forms will be available at all contracted facilities, from the website at www.caldental.net, or by calling the California Dental Network toll- free at (877) 4-DENTAL (433-6825). Each facility will be asked to have a designated staff member available to assist Plan Members in the filing of a complaint or grievance. Completed Grievance Forms should be mailed to California Dental Network's administrative office.

Members, or their representatives, with limited English proficiency or with visual or other communicative impairment can receive assistance by contacting the Plan at (877) 4-DENTAL (433-6825).

Resolution Process

A designated California Dental Network staff member will handle written and oral complaints. Any inquiry which may be interpreted as a complaint or grievance will be recorded. The Plan's grievance system is comprised of the following:

- If a Member complaint is received by phone and does not involve a coverage issue, Member Services will attempt to resolve the complaint before the close of the next business day. If Member Services is successful, the resolution of the complaint will be communicated to all parties by phone and will be recorded by the Member Services staff member in the Telephone Exempt Grievance Log.

- If a Member complaint is received by phone and involves a coverage issue (a member and/or provider disputing what is covered and not covered by the product) the member services staff will record the coverage dispute conversation in the Telephone Log. If the complaint is resolved before the close of the next business day, the member services staff will log the resolution in the Plan Telephone Log. Plan Grievances and Appeals department staff will review the Plan Telephone log and send the Plan Coverage Dispute acknowledgement/resolution letter to the member. The initial resolution of the complaint will be communicated to all parties by phone, with the final letter sent within 5 calendar days to the member.

- If a Member complaint is received and is identified by the Grievance Coordinator as urgent, the member will be contacted by phone to facilitate the resolution of the urgent nature of the grievance, and letter to the member regarding the status of the urgent nature of the grievance will be mailed within 3 days of receipt of the grievance.

- All other complaints will be acknowledged within five calendar days upon receipt by the Plan. A letter of acknowledgment will be sent to the Member which will include the name of a designated California Dental Network staff member that they may contact for questions or the status of their complaint or grievance.

- A grievance file will be opened and hard copies of the grievance, acknowledgement and records request letters, membership information for the Member, all records and e-mail correspondence will be maintained in the file. The file will contain a Grievance processing Form (See Exhibit A) on which will be recorded the name of the Member the name of the provider(s) involved in the grievance, as well as the name and contact information for the person the Provider(s) has/have designated for the Plan to speak with regarding the grievance.

On the Grievance Processing Form information about the important dates in the processing of the grievance (date received, acknowledged, records received, QA review, etc) will be recorded. A written record shall be maintained in the file of all oral conversations that take place during the course of the grievance investigation, including the date of the conversation and the names of the persons involved.

Those grievances involving quality of care issues will be reviewed by the Dental Director, who will document the review and findings on the Quality of Care Review page of the Grievance Processing form.

The Plan will classify grievances into 5 severity categories (see GA001 Attachment, Page 8):

0) No quality of care issue identified- (ex. Financial Issue (covered benefits, copayment, incorrect billing), In-office waits, Rude staff, Patient dental record in total conflict with complaint.)
1) Known and expected complication of care occurred; no evidence of improper care- (ex. Pain after

filling, crown, extraction, etc., Adverse reaction to local anesthesia or prescription, Root canal needed after filling, crown.)

2) Confirmed quality issue in which care had the potential for mild adverse effect on Member- (ex. Inadequate documentation in chart, Failure to provide preventive care, Failure to timely follow up on observed mild dental/oral conditions.)
3) Confirmed quality issue in which care resulted in mild adverse effect on Member- (ex. Prolonged treatment/excessive remakes, Delivery of ill-fitting denture, filling, crown, etc. resulting in discomfort (sore spots, food impaction, etc.) but no irreversible damage.)
4) Confirmed quality issue in which care had potential for or resulted in significant adverse effect on Member-Prescription of antibiotic to allergic person, Delivery of ill-fitting fillings, crowns, bridges resulting in recurrent decay or periodontal damage, Treated wrong tooth, Tooth damaged from improper treatment.

- If the grievance investigation determines that corrective action is needed on the part of the provider the Plan will initially inform the provider and obtain agreement to the proposed corrective action by telephone, fax or e-mail, in order to ensure timely resolution of the grievance.

- Once the grievance is closed the Plan shall provide written notification to the Member in the form of a grievance resolution letter. The Plan shall also provide a copy of the grievance resolution letter to the provider as well as a grievance closing letter to the provider that summarizes the telephone, fax or e-mail discussions of any quality or corrective action issues that were discussed.

- If corrective action was indicated the letter to the provider will also document the type of follow-up the Plan will do to verify the corrections have taken place (example; follow calls, office audit, etc), as well as the timeframe for the Plan's follow-up with the provider and will advise the provider that following review by the QAC/PRC the Plan may request additional action on the part of the provider to correct a potential quality issue.

- California Dental Network will provide Members with a written statement as to the disposition of their non-exempt complaints or grievances within 30 days of receipt. All complaints and grievances will be resolved within a 30-day period. Plan subscribers will receive written responses to grievances, with a clear and concise explanation of the reasons for the Plan's response. (Sixth grade reading level or below).

- 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 providers, issues a decision delaying, denying, or modifying healthcare 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 enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

- For grievances involving the delay, modification, or denial of services based on a determination in whole or in part that the service was not medically necessary the Plan's grievance resolution letters shall include an application for an independent medical review (IMR) with instructions and an envelope addressed to the Department of Managed Health Care.

- The designated California Dental Network staff member will record information regarding any complaint or grievance received in person, by telephone, or in writing, in the Plan's grievance log. The purpose of the grievance log is to maintain a central file of all complaints and grievances received by the Plan. The grievance log will include information such as date complaint or grievance is received, Member information, facility and provider information, person receiving the grievance, classification of the type of complaint or grievance (based upon the classification system utilized by the DMHC), the

current status, the date of resolution, any follow up needed with the provider, the interval for that follow-up, and the date follow-up completed.

- Members will receive a written response regarding the resolution of their non-exempt complaint or grievance including notification of the process by which the Member may appeal the decision if the complaint has not been resolved to their satisfaction.

- If the Member is dissatisfied with the resolution, the Member may complain to the California Department of Managed Healthcare.

- Per the Department of Managed Health Care regulations, an enrollee, subscriber, or group contract holder's grievance to the Director of the DMHC shall be processed to determine if a proper complaint exists, including a determination if the grievance is timely, complete, and within the DMHC Director's jurisdiction. If a proper complaint does exist, the DMHC Director shall notify the enrollee, subscriber, or group contract holder, and The Plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint. Within 1 business day of receipt of the Department's notice of acceptance of proper complaint, The Plan shall provide the Director with a copy of all information The Plan used to make its determination and all other relevant information necessary for the Department's review.

Statutory/Regulatory Citations:

- California Code of Regulations, Title 28, Section 1300.68 Grievance System

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review
9/27/2022	Updates based on DMHC Preliminary Survey Report
10/10/2022	Updates based on Plan Management team discussion.

Complaints, Grievances, and Appeals	California Dental Network A DentaQuest company			
	Policy and Procedure			
	Policy Name:	**CGA Member Grievance Process**	Policy ID:	**PLANCDN-32**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Complaints, Grievance and Appeals Member Grievance Process

Purpose

To establish the California Dental Network Complaints, Grievances and Appeals Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

A grievance is defined as a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a member or the member's representative. In cases where CDN is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. The member does not need to intend to submit a grievance—the issue becomes a grievance the moment the member expresses dissatisfaction regarding the Plan or provider.

This policy aims to receive and resolve complaints, grievances and appeals in a manner that is fair, efficient and confidential and takes into account the needs, rights and responsibilities of the involved parties.

Policy

The Grievance Process investigates, reviews, and resolves Member complaints and grievances. Any information collected that involves a utilization problem is reported to the DD. The Grievance representative on the QAC also makes a direct report to the QAC concerning grievance activity in the preceding quarter. This information can also be made available upon request to the PRC. Also by policy, all quality of care grievances that demonstrated a moderate adverse effect on the Member or have the potential for serious adverse effect must be reported to the PRC.

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 Provider'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 Dr, Ste 100
Phone (949) 830-1600: Toll-Free (877) 4-DENTAL
Fax (949) 830-1655

Completed Grievance Forms must be mailed to CDN at the address listed above. Members can also submit Grievances online at CDN's website: www.caldental.net

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.

California Dental Network 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. A written response will be sent within 30 days advising the member 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 providers, 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, or involves the cancellation, rescission, or termination of a member, the time period for Plan action as set forth above shall not apply. Upon the Plan's receipt of an urgent or emergency grievance, Plan Members will be immediately informed via telephone of the availability of their right to contact the Department of Managed Health Care regarding their grievance. Such phone calls will be documented in the Plan Grievance Log and include date of call as well as the name Plan staff member making the calls. In urgent or emergency 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 **1-714-479-0777 or toll-free 1-877-4-DENTAL** and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.dmhc.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.

Statutory/Regulatory Citations:

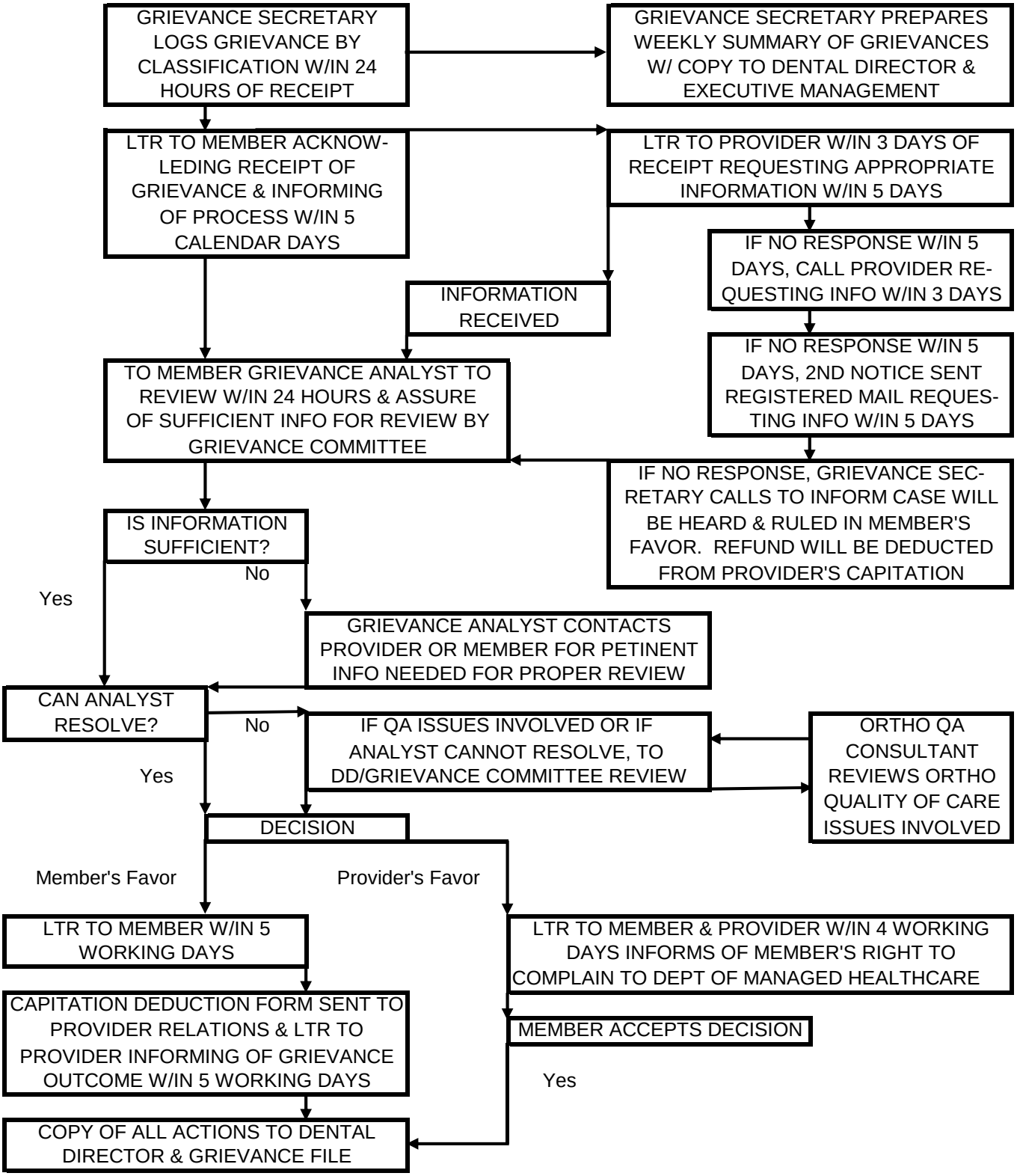
- California Code of Regulations, Title 28, Section 1300.68 Grievance System

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review
9/27/2022	Updates based on DMHC Preliminary Survey Report
10/10/2022	Updates based on Plan Management team discussion.

CALIFORNIA DENTAL NETWORK

MEMBER GRIEVANCE FLOWCHART



CG&A DEPARTMENT	California Dental Network A DentaQuest company		
	Policy and Procedure		
	Policy Name:	**CGA Provider Dispute Resolution**	Policy ID:	**PLANCDN-34**
	Approved By:	Quality Assurance Committee	Last Revision Date:	10/10/2022
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Provider Dispute Resolution

PURPOSE

To establish the California Dental Network Complaints, Grievances and Appeals Program policies and procedures as defined by the requirements of the Covered California Exchange and/or the Department of Managed Health Care as applicable.

This policy aims to receive and resolve complaints, grievances and appeals in a manner that is fair, efficient and confidential and takes into account the needs, rights and responsibilities of the involved parties.

POLICY

California Dental Network will communicate in writing to its contracted providers the Provider Dispute Resolution Process, through the Provider Manual, which is distributed at the time the provider is accepted on the panel. Non-contracted providers will be notified in writing through the Plan's specialty referral and claims processes. A toll-free number will be available for providers to submit a dispute, which is accessible from all of California Dental Network's service areas.

Dispute Resolution Process

A designated staff member will handle written or oral disputes. All disputes will be resolved within 30 days wherever possible.

The dispute resolution process is comprised of the following:

All disputes will be acknowledged within 5 working days. A letter of acknowledgement will be sent to the provider, which will include the name of the designated staff member they may contact for questions.

The designated staff member will record the dispute in the Plan's dispute resolution log. The log will maintain information such as: the date that the dispute was received, provider name, grievance type or description, and resolution date of the dispute.

The designated staff member will investigate and attempt to resolve the dispute by promptly obtaining all pertinent information. Any dispute related to quality-of-care issues will be given to the Plan Dental Director for review and resolution. The resolution of the dispute will be recorded in the dispute log.

The provider will receive written notification of the dispute resolution. The notification will include the process by which the resolution may be appealed if not resolved to their satisfaction.

A dispute resolution may be appealed to the Public Policy Committee by writing to the Plan within 45 days of receipt of the initial resolution. Those dispute resolutions involving quality of care may be subject to prior review by the Quality Assurance/Peer Review Committee and their recommendations forwarded to the Public Policy Committee for its use during review of the appeal.

If the Provider is dissatisfied with the Public Policy Appeal Resolution the provider may appeal to the Department of Managed Health Care's provider grievance unit.

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (1-888-HMO- 2219) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 1- 949-830-1600 or toll-free 1-877-4-DENTAL and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Expedited Resolution
If the dispute requires an immediate resolution for an urgent or emergency quality of care issue the time period for the Plan action, as set forth above shall not apply. In such cases the Plan will handle the dispute within a timeframe appropriate for the situation.

Reporting and Review
The designated Plan staff will review the dispute resolution log on a weekly basis to ensure that the Plan's 30-day resolution standard will be met in all cases possible.

The designated Plan staff will compile a quarterly report of the dispute resolution log, which will be presented to the Quality-of-Care Quality Assurance/Peer Review and Public Policy committees for review. Any findings or recommendations will be presented to the Board of Directors.

Statutory/Regulatory Citations:

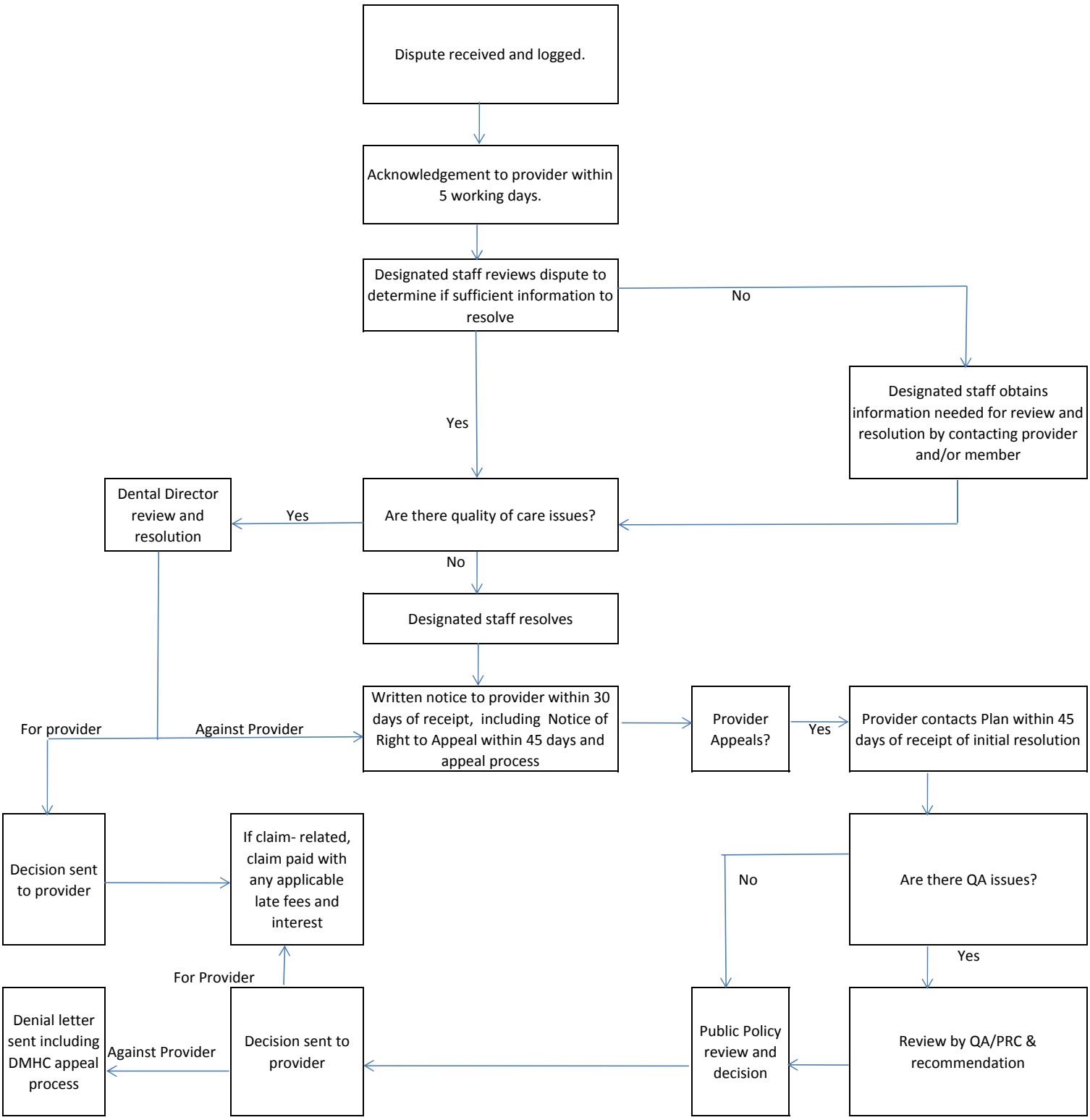
- California Code of Regulations, Title 28, Section 1300.68 Grievance System

Revision History

Date:	Description
08/24/2021	Approval and Adoption
07/08/2022	Conversion to revised policy and procedure format and naming convention.
07/12/2022	Updates based on DMHC TAG Review
10/10/2022	Updates based on Plan Management team discussion.

PROVIDER DISPUTE RESOLUTION FLOWCHART

Provider Dispute Resolution



GUIDELINES FOR GENERAL DENTISTS

Miscellaneous

- COBRA Explanation
- Coordination of Benefits
- Non-Pharmacological and Non-Opioid Pain Management Policy
- Outpatient Psychotherapy

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COBRA EXPLANATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted in April 1986. This law allows (under specific circumstances) Members and their dependents of groups employing more than 20 employees (excluding churches and federal government health plans) to maintain the same health care benefits after their coverage would have normally ended.

- **ELIGIBILITY AND DURATION OF COVERAGE**

  18 months as follows:
  - Termination of employment.
  - Loss of coverage due to reduction of work hours.

  36 months as follows:
  - Divorce.
  - Death of covered employee.
  - Legal separation.
  - Employee spouse eligible for Medicare.
  - No longer eligible as dependent child.

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 plan, then the benefits of this plan shall be coordinated with the other plan according to regulations on "Coordination of Benefits". 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 OR PPO (PREFERRED PROVIDER ORGANIZATION)PLAN**

  If the group indemnity/PPO coverage is primary, the provider will usually bill the indemnity/PPO carrier for their Usual and Customary Fees, and the Member will be charged the co-payment under the secondary plan less the amount received from the primary coverage.

  If the group indemnity/PPO coverage is secondary, the provider will bill the carrier for the amount of co-payments under the primary plan, and the Member will be responsible for the co-payments 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 co-payment(s) of the two plans.

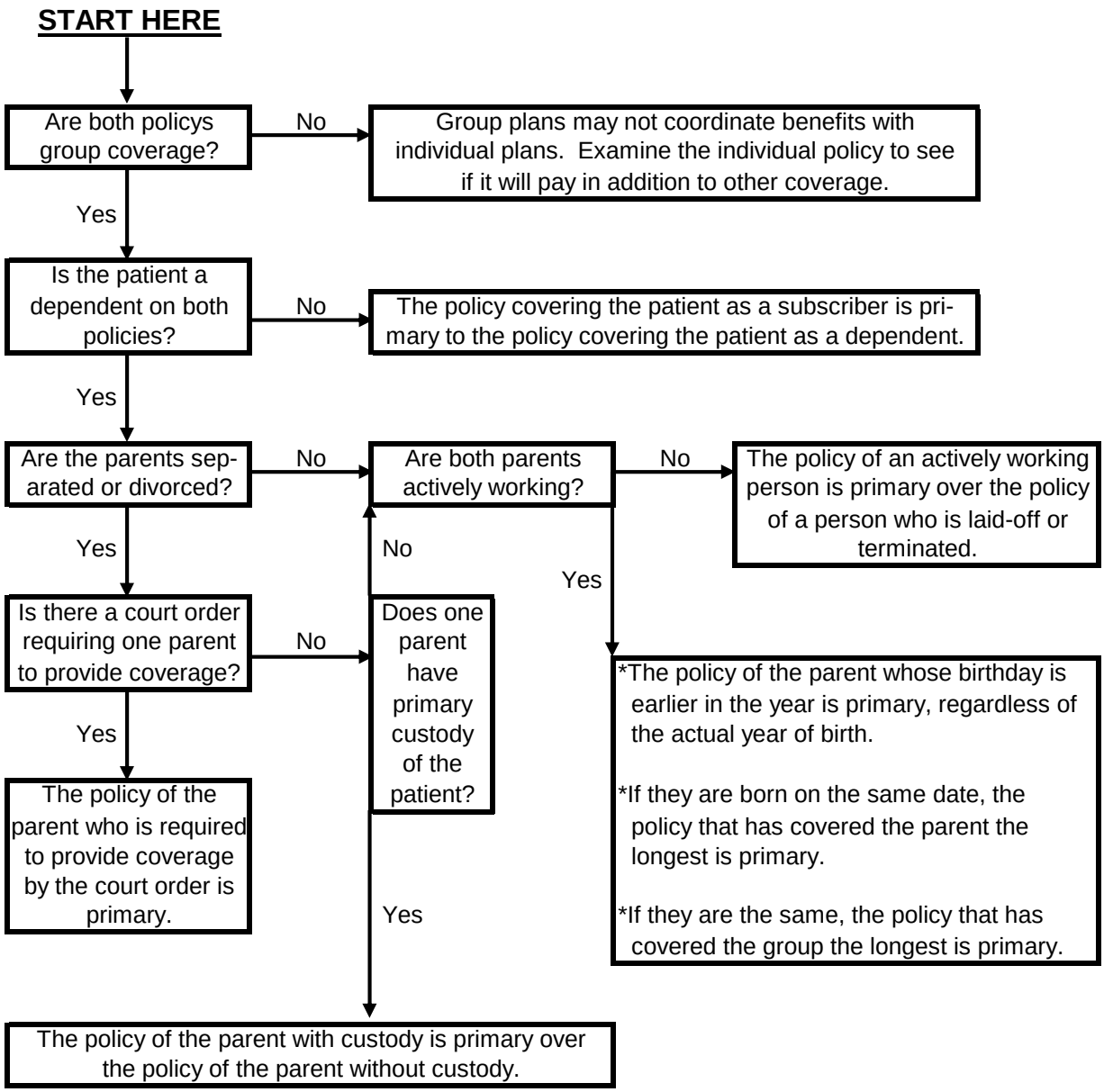
  If the provider does not participate in both plans, the plan that the provider participates in will be primary, and the other plan will typically deny coverage because the Member received services from a non-participating provider.

  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 California Dental Network.

COORDINATION OF BENEFITS

PRIMARY DETERMINATION FLOWCHART



If you have questions regarding Coordination of Benefits, please feel free to call CALIFORNIA DENTAL NETWORK toll-free at (877) 4-DENTAL (433-6825).

Utilization Management	California Dental Network A DentaQuest company		
	Policy and Procedure		
	Policy Name:	**Non-Pharmacological and Non-Opioid Pain Management Policy**	Policy ID:	**PLANCDN-20**
	Approved By:	Elizabeth Henderson, Clinical Director	Last Revision Date:	03/15/2023
	States:	California	Last Review Date:	05/21/2024
	Application:	Commercial	Effective Date:	05/22/2024

Non-Pharmacological and Non-Opioid Pain Management Policy

Purpose

To encourage contracted providers to use non-pharmacological and especially non-opioid pain management strategies whenever practical in the management of Member pain related to Plan-covered conditions, and to encourage Members to participate and cooperate with their contracted providers in the non-pharmacological and especially non-opioid management of those conditions.

Policy

A) The Plan's provider manual and outreach materials to contracted providers (provider newsletters) encourage contracted providers to follow the recommendations in the 2016 ADA Statement on the Use of Opioids in the Treatment of Dental Pain:

- When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
- Dentists should follow and continually review Centers for Disease Control and state licensing board recommendations for safe opioid prescribing.
- Dentists should register with and utilize prescription drug monitoring programs (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
- Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.
- Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.
- Dentists should consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.
- Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.
- Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.
- Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
- Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

B) The Plan's outreach materials and modalities to Plan Members (printed/mailed materials, email outreach, and Plan website) provide support and encouragement to Plan Members to participate and cooperate with contracted providers in the non-pharmacological and especially non-opioid management of pain related to Plan-covered conditions.

C) The Plan monitors provider use of appropriate pain-management strategies during periodic routine

dental office assessments/audits, grievance, and Member satisfaction reporting.

D) The Plan's provider manual and outreach materials to contracted providers (provider newsletters) encourage contracted providers to promote behavior modification techniques for non-pharmacological pain management including: voice control, positive reinforcement, modeling, "tell, show, do" relaxation training, and modeling.

E) To promote non-pharmaceutical management of dental anxiety or phobia, the Plan encourages Providers to support meditation, deep breathing, distraction (such as listening to music), guided imagery and progressive muscle relaxation for Plan Members.

DEFINITIONS:

"Nonpharmacological pain management treatment" means pain management treatment without the use of medication, including behavioral therapy, instrument-based therapy, or immersive therapeutics approved by the federal Food and Drug Administration indicated for the use of managing or treating pain.

Statutory/Regulatory Citations:

- CA Health & Safety Code § 124962 (2022)

Revision History

Date:	Description
03/29/2023	Approval and Adoption

OUTPATIENT PSYCHOTHERAPY

Any request for records that specifically relate to patient's participation in outpatient psychotherapy must include the following:

1. Specific information requested, specific use of that information, and length of time that information will be kept before being destroyed.

2. The request must contain a statement that the information will not be used for any other purpose but the intended purpose stated, and the information will be destroyed or returned (including copies under their control) after the length of time has expired.

3. That the requesting party will submit a copy of the request within 30 days of receipt of the information to the patient, unless the patient has signed a waiver.