

**Principal Benefits & Coverage Plan**  
**Advantage 200 Plus**

- ❖ 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.

| <u>CODE</u>  | <u>DESCRIPTION</u>   | <u>MEMBER COPAYMENT</u> |
|--|--|-------------------------|
| <b><u>DIAGNOSTIC SERVICES</u></b>  |  |                         |
| 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                  |
| <b><u>PREVENTIVE SERVICES</u></b>  |  |                         |
| # - 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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| <u>CODE</u>  | <u>DESCRIPTION</u>   | <u>MEMBER<br/>COPAYMENT</u>         |
|--|--|-------------------------------------|
| 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                             |
| <b><u>RESTORATIVE SERVICES</u></b>   |  |                                     |
| 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                            |
| <b><u>INLAYS/ONLAYS</u></b>  |  |                                     |
| 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                            |
| <b><u>CROWNS</u></b>   |  |                                     |
| 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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| <u>CODE</u>  | <u>DESCRIPTION</u>  | <u>MEMBER<br/>COPAYMENT</u>  |
|--|---|--|
| 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   |
| <b><u>LABIAL VENEERS (REPLACED ONCE EVERY 5 YEARS WHEN DENTALLY NECESSARY)</u></b>   |   |  |
| 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  |
| <b><u>ALTERNATIVE CROWNS</u></b>   |   |  |
| 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   |
| <b><u>ENDODONTICS (EXCLUDING FINAL RESTORATIONS)</u></b>   |   |  |
| 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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| <u>CODE</u>   | <u>DESCRIPTION</u>   | <u>MEMBER<br/>COPAYMENT</u> |
|---|--|-----------------------------|
| 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 - <i>subject to proper documentation of condition and procedure. See clinical guidelines.</i>  | 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                     |
| <b>PERIODONTICS</b>   |  |                             |
| # - 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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| <u>CODE</u>   | <u>DESCRIPTION</u>   | <u>MEMBER<br/>COPAYMENT</u> |
|---|--|-----------------------------|
| 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                     |
| <b>REMOVABLE PROSTHODONTICS</b>   |  |                             |
| 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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| <u>CODE</u>  | <u>DESCRIPTION</u>   | <u>MEMBER<br/>COPAYMENT</u> |
|--|--|-----------------------------|
|  | 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                    |
| <b>D5900 - D5999 VII MAXILLOFACIAL PROSTHETICS - NOT COVERED</b>   |  |                             |
| <b>IMPLANT SERVICES</b>  |  |                             |
| INCLUDES LAB COSTS, TEMPORIZATION, AND REMOVAL OF EXISTING RESTORATIONS.   |  |                             |
| 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 COVERED MATERIALS AND APPLICABLE COPAYMENTS. |  |                             |
| <b>D6010</b>   | Surgical placement of implant body, endosteal; includes cost of, and placement of, healing cap when indicated.   | \$1,500.00                  |
| <b>D6056</b>   | Prefabricated abutment, includes placement   | \$450.00                    |
| <b>D6058</b>   | Abutment supported porcelain/ceramic crown   | \$1,055.00                  |
| <b>D6059</b>   | Abutment supported porcelain/high noble crown  | \$1,050.00                  |
| <b>D6060</b>   | Abutment supported porcelain/base metal crown  | \$1,000.00                  |
| <b>D6061</b>   | Abutment supported porcelain/noble metal crown   | \$1,050.00                  |
| <b>D6062</b>   | Abutment supported cast metal crown, high noble  | \$1,050.00                  |
| <b>D6063</b>   | Abutment supported cast metal crown, base metal  | \$900.00                    |
| <b>D6064</b>   | Abutment supported cast metal crown, noble metal   | \$950.00                    |
| <b>D6065</b>   | Implant supported porcelain/ceramic crown  | \$990.00                    |
| <b>D6066</b>   | Implant supported porcelain/metal crown  | \$970.00                    |
| <b>D6067</b>   | Implant supported metal crown  | \$935.00                    |
| <b>D6068</b>   | Abutment supported retainer, porcelain/ceramic FPD   | \$1,055.00                  |
| <b>D6069</b>   | Abutment supported retainer, metal FPD, high noble   | \$1,040.00                  |
| <b>D6070</b>   | Abut. support. retainer, porc./metal FPD, base metal   | \$985.00                    |
| <b>D6071</b>   | Abut. support. retainer, porc./metal FPD, noble  | \$1,000.00                  |
| <b>D6072</b>   | Abut. support. retainer, cast metal FPD, high noble  | \$980.00                    |
| <b>D6073</b>   | Abut. support. retainer, cast metal FPD, base metal  | \$885.00                    |
| <b>D6074</b>   | Abut. support. retainer, cast metal FPD, noble   | \$955.00                    |
| <b>D6075</b>   | Implant supported retainer for ceramic FPD   | \$1,040.00                  |
| <b>D6076</b>   | Implant supported retainer for porc./metal FPD   | \$1,015.00                  |
| <b>D6077</b>   | Implant supported retainer for cast metal FPD  | \$935.00                    |
| <b>D6081</b>   | 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                     |
| <b>D6085</b>   | Provisional implant crown  | \$0.00                      |
| <b>D6092</b>   | Recement implant/abutment supported crown  | \$45.00                     |

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|  |   |                                     |
|--|---|-------------------------------------|
| <b>D6093</b>   | Recent implant/abutment supported FPD   | \$65.00                             |
| <b>D6094</b>   | Abutment supported crown, titanium  | \$640.00                            |
| <b>D6194</b>   | Abut. supported retainer crown, FPD, titanium   | \$640.00                            |
| <b>FIXED PROSTHODONTICS</b>  |   |                                     |
| 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                            |
| 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  | Recent 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

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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     |
| 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, anxietyolysis, 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, <b>with prior authorization from Plan</b> . 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   |

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|       |  |          |
|-------|--|----------|
| 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:

- 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.
- A200+S** 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.
- A200+V** 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,

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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.
- 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.

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- 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 relines 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:
  - 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.

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- Treatment using plastic aligners (i.e. Invisalign®, Clear Correct®, Red White & Blue®).

### **ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR IMPLANTS**

Implants are a **covered benefit only for Groups on Advantage Group Plans that have purchased the OPTIONAL CDN Implant Benefit Rider.** Refer to your included Schedule of Benefits and Covered Services for a listing of your covered benefits.

- All covered implant services are subject to eligibility and dental necessity at the time of service, and must be recommended by the dentist.
- Implants are limited to no more than once for the same tooth position in a five (5) year period.
- Implant supported prosthetics are limited to no more than once for the same tooth position in a five (5) year period:
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth
- Implants, Implant supported prosthetics, and Implant abutments are limited to no more than two (2) each per year.
- Dental procedures not listed are available at the dental office's usual and customary fee.

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

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