blue of california COVERED CALIFORNIA

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Family Dental HMO
Type of Product Line: DHMO
Effective Date: Beginning On or After 1/1/25

Name of Product: A51672
Plan Phone #: 1-888-256-3650
Plan Website: blueshieldca.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE blueshieldca.com OR CALL 1-888-256-3650. THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Pediatric: None Adult: None	Pediatric: Not applicable Adult: Not applicable
Orthodontia	Pediatric: None Adult: None	Pediatric: Not applicable Adult: Not applicable

- There is no deductible.
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Pediatric Out-of-Pocket Max: $350 per individual; $700 per family Adult Out-of-Pocket Max: No maximum Pediatric/Adult Benefit Max: No maximum	Pediatric: Not applicable Adult: Not applicable
Lifetime or Annual Maximum for Orthodontia	Pediatric: No maximum Adult: Not applicable	Pediatric: Not applicable Adult: Not applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	$0 pediatric $0 adult	Not covered	Comprehensive oral evaluation:

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				Pediatric: Once per member per provider for the initial evaluation. Adult: Comprehensive oral evaluations listed here are limited to one in a 3-year period. Periodic oral evaluations have a separate cost share and limitation. Please see the *Summary of Benefits* for information.
Bitewing X-ray	Preventive & Diagnostic	$0 pediatric $0 adult	Not covered	Bitewing radiograph – single film: Pediatric: Once per date of service. Adult: Two sets of single films or one set of two films every 6 months.
Cleaning	Preventive & Diagnostic	$0 pediatric $0 adult	Not covered	Prophylaxis: Pediatric: One in a 6-month period. Adult: One in a 6-month period.
Filling	Basic	$30/tooth pediatric $30/tooth adult	Not covered	Resin-based composite – one surface, anterior: Pediatric: Once per tooth in a 12-month period for primary teeth and once in a 36-month period for permanent teeth. Adult: Once per tooth in a 12-month period.
Extraction, Erupted Tooth or Exposed Root	Major	$65/tooth pediatric $65/tooth adult	Not covered	Extraction – erupted tooth or exposed root, including elevation and/or forceps removal: Pediatric: Not a Benefit when removed by the same provider who performed the initial tooth extraction. Adult: Once per tooth.
Root Canal	Major	$300/tooth pediatric $300/tooth adult	Not covered	Endodontic therapy – molar tooth (excluding final restoration): Pediatric: Once per tooth for initial root canal therapy treatment. Adult: One per tooth, per lifetime.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Scaling and Root Planing	Major	$55/quadrant pediatric $55/quadrant adult	Not covered	Periodontal scaling and root planing – four or more teeth - per quadrant: Pediatric: Once per quadrant every 24-months and limited to members age 13 or older. Adult: Once per quadrant in a 24-month period; two quadrants per visit.
Ceramic Crown	Major	$300/tooth pediatric $300/tooth adult	Not covered	Crown – porcelain/ceramic: Pediatric: Permanent anterior teeth and permanent posterior teeth (ages 13 or older) once in a 5 year period. Adult: One per tooth in a 5-year period.
Removable Partial Denture	Major	$335/denture pediatric $375/denture adult	Not covered	Maxillary partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests, and teeth: Pediatric: One in a 5-year period. Adult: One in a 5-year period.
Extraction, Erupted Tooth with Bone Removal	Major	$120/tooth pediatric $115/tooth adult	Not covered	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated: Pediatric: 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. Adult: Once per tooth.
Orthodontia	Orthodontia	$350 pediatric Not covered adult	Not covered	Pediatric: Refer to the *Evidence of Coverage* for a list of benefit limitations and exclusions. Adult: Not a benefit.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (full mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: Not applicable	Deductible	In-network: $0 Out-of-network: Not applicable	Deductible	In-network: $0 Out-of-network: Not applicable
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $30/tooth Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $300/tooth Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $0 Out-of-network: $550**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $30 Out-of-network: $200**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $300 Out-of-network: $1,750**

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Summary of what is not covered or subject to a limitation:	**Exam:** Adult: One in a 3-year period. **X-rays (full-mouth x-ray):** Adult: Two sets of single films or one set of two films every 6 months. **Cleaning:** Adult: One in a 6-month period.	Summary of what is not covered or subject to a limitation:	Adult: Once per tooth in a 12-month period.	Summary of what is not covered or subject to a limitation:	Adult: One per tooth in a 5-year period.

Family Dental HMO Plan

Evidence of Coverage and Health Service Agreement

Individual and Family Plan

An independent member of the Blue Shield Association

(Intentionally left blank)

Blue Shield of California
Individual and Family
Family Dental HMO Plan

Evidence of Coverage and
Health Service Agreement

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service Plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Premiums, Blue Shield of California agrees to provide the Benefits of this Agreement.

NOTICE TO NEW SUBSCRIBERS

Please read this Service Agreement carefully. If you have any questions, contact Blue Shield. You may surrender this Agreement by delivering or mailing it with the identification cards, within ten (10) days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 601 12th STREET, OAKLAND, CALIFORNIA 94607. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and Premiums paid will be refunded.

IMPORTANT!

No Person has the right to receive the Benefits of this Plan for services or supplies furnished following termination of coverage. Benefits of this Plan are available only for services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Agreement or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Agreement.

IMPORTANT!

If you opt to receive dental services that are not Covered Services under this Plan, a participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-877-885-0254 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

Table of Contents

Summary of Benefits 5

Introduction to the Blue Shield Family Dental HMO Plan 9

Conditions of Coverage 9

Eligibility and Enrollment 9

Duration of the Agreement 12

Premiums 13

Service Area 13

Choice of Dental Provider 13

How to Use Your Dental Plan 15

Plan Benefits 16

Responsibility for Copayments, Charges for Non-Covered Services, and Emergency Claims 17

General Exclusions and Limitations 17

Other Provisions 22

Member Services and Grievance Process 26

Definitions 28

Dental Schedule and Limitations Table 34

blue of california

COVERED CALIFORNIA

Summary of Benefits

Individual and Family Dental Plan

DHMO Plan

Family Dental HMO

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)[1]. Please read both documents carefully for details.

This Plan has separate Benefits for Pediatric Members and Adult Members. Pediatric Benefits are available for Members through the end of the month in which the Member turns 19. Adult Benefits are available for Members 19 and older.

Dental Provider Network: **DHMO Network**

This Plan uses a specific network of dental care providers, called the DHMO provider network. Dentists in this network are called Participating Dentists. You must select a Participating Dentist from this network to provide your primary dental care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Dentist[3]
Calendar Year Pediatric Deductible	*Individual coverage*	$0
	Family coverage	$0
Calendar Year Adult Deductible	*Individual coverage*	$0
	Family coverage	Not applicable

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

		When using a Participating Dentist[3]
Calendar Year Pediatric Out-of-Pocket Maximum	*Individual coverage*	$350
	Family Coverage	$350: individual $700: Family
Calendar Year Adult Out-of-Pocket Maximum	*Individual coverage*	No maximum
	Family Coverage	Not applicable

Blue Shield of California is an independent member of the Blue Shield Association

Calendar Year Benefit Maximum

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

		When using a Participating Dentist[3]
Calendar Year PediatricBenefit Maximum	*Individual coverage*	No maximum
	Family coverage	No maximum
Calendar Year Adult Benefit Maximum	*Individual coverage*	No maximum
	Family coverage	Not applicable

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Pediatric waiting period	No waiting period
Adult waiting period	No waiting period

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Pediatric Benefits[5,6]	Your payment
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**
Office visit	$0
Diagnostic and preventive services	
Oral exam	$0
Preventive – cleaning	$0
Preventive – x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers – fixed	$0
Basic services	
Restorative procedures Periodontal maintenance Adjunctive general services	See Dental Copay Schedule in Evidence of Coverage
Major services	
Oral Surgery Endodontics Periodontics (other than maintenance) Crowns and casts Prosthodontics	See Dental Copay Schedule in Evidence of Coverage
Orthodontics (Medically Necessary)	$350

Adult Benefits[5,6]	Your payment
Adult Benefits are available for Members age 19 and older.	**When using a Participating Dentist[3]**
Office visit	$0
Diagnostic and preventive services	
Oral exam	$0
Preventive – cleaning	$0
Preventive – x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers – fixed	$0
Basic services	
Restorative procedures	See Dental Copay Schedule in Evidence of Coverage
Periodontal maintenance	
Adjunctive general services	
Major services	
Oral Surgery	See Dental Copay Schedule in Evidence of Coverage
Endodontics	
Periodontics (other than maintenance)	
Crowns and casts	
Prosthodontics	
Orthodontics (Medically Necessary)	Not covered

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Notes

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. Once you reach the OOPM, the Plan will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

This Plan has separate Out-of-Pocket Maximums for:

- Pediatric OOPM and Adult OOPM
- Participating Dentist OOPM and Non-Participating Dentist OOPM

Individual Pediatric OOPM. Cost sharing payments made by each Pediatric Member for in-network Covered Services accrue to the individual OOPM.

Individual Adult OOPM. Cost sharing payments made by each Adult Member for in-network Covered Services accrue to the individual OOPM.

Family Pediatric OOPM. Family coverage applies to two or more Pediatric Members only. In a plan with two or more Pediatric Members, cost sharing payments made by each Pediatric Member for in-network services contribute to both the individual in-network OOPM and the family in-network OOPM.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

6 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Dental Covered Services. All Covered Services must be Medically Necessary and must be provided by the Member's Dental Center or other Participating Dentist when referred by the Member's Dental Center and Authorized by the contracted Dental Plan Administrator.

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary Orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

Teledentistry. To the extent this Plan offers teledentistry, it is offererd at no charge.

Other Covered Services. Tooth whitening, Adult orthodontia, Implants, veneers, and Adult services noted as Not Covered on the Dental Schedule and Limitations Table in the EOC are not covered services.

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.

These endnotes do not limit and issuer's obligations to comply with applicable federal, state, or local laws, rules or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these endnotes.

Introduction to the Blue Shield Family Dental HMO Plan

Your interest in the Blue Shield Family Dental HMO Plan is appreciated. Blue Shield has been serving Californians for over 75 years, and we look forward to serving your dental care needs.

The Blue Shield Family Dental HMO Plan offers you a dental Plan with a wide choice of Plan Dental Providers. All Covered Services will be provided by or arranged through your Dental Center.

You will have the opportunity to be an active participant in your own dental care. Blue Shield of California Family Dental HMO Plan will help you make a personal commitment to maintaining and, where possible, improving your dental health status. Like you, we believe that maintaining a healthy lifestyle and preventing dental illness are as important as caring for your needs when dental problems arise.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Family Dental HMO Plan.

Blue Shield's dental plans are administered by a Dental Plan Administrator (DPA), which is an entity that contracts with Blue Shield to administer the delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

This plan has separate Benefits for Pediatric Members and Adult Members. Pediatric dental Benefits are available for Members through the end of the month in which the Member turns 19. Adult dental Benefits are available for ages 19 and older.

This dental Plan is offered through Covered California. For more information about Covered California, please visit www.coveredca.com or call 1-888-975-1142. If you have any questions regarding the information in this booklet, need assistance, or have any problems, you may contact your Dental Plan Member Services Department at: 1-877-885-0254.

Conditions of Coverage

Eligibility and Enrollment

This section explains eligibility and enrollment for this plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this plan

Covered California determines if you are a Qualified Individual eligible to enroll and continue enrollment in this plan. To enroll in this plan, you must be a Resident of California. Visit coveredca.com for more information about Covered California eligibility requirements.

Dependent eligibility

To be eligible for coverage as a Dependent, the individual must meet all eligibility requirements listed above, as well as certain Covered California Dependent eligibility requirements. The individual must:

1. Be listed on the enrollment form completed by the Subscriber; and
2. Be the Subscriber's spouse, Domestic Partner, or be under age 26 and the child of the Subscriber, spouse, or Domestic Partner.

   a) For the Subscriber's spouse to be eligible for this plan, the Subscriber and spouse must not be legally separated.
   b) For the Subscriber's Domestic Partner to be eligible for this plan, the Subscriber and Domestic Partner must have a registered domestic partnership.
   c) "Child" includes a stepchild, newborn, child placed for adoption, child placed in foster care, and child for whom the Subscriber, spouse, or Domestic Partner is the legal guardian. It does not include a grandchild unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
   d) A child age 26 or older can remain enrolled as a Dependent if the child is disabled, incapable of self-support because of a mental or physical disability, and chiefly dependent on the Subscriber for economic support.

      i. The Dependent child's disability must have begun before the period he or she would become ineligible for coverage due to age.
      ii. Blue Shield will send a Notice of Termination due to loss of eligibility 90 days before the date coverage will end. The Subscriber must inform Covered California of the Dependent's eligibility for continuation of coverage within 60 days of receipt of this notice in order to continue coverage.
      iii. The Subscriber must submit proof of continued eligibility for the Dependent at Blue Shield's request. Blue Shield may not request this information again for two years after the initial determination. Blue Shield may request this information no more than once a year after that. The Subscriber's failure to provide this information could result in termination of a Dependent's coverage.

Enrollment and effective dates of coverage

As the Subscriber, you can apply for coverage for yourself and your Dependents during the annual open enrollment period. You can also apply for coverage for yourself and your Dependents if you qualify for a special enrollment period.

This Agreement covers the Subscriber and any enrolled Dependents for one plan year. A plan year begins on January 1 and ends on December 31 of that same year.

The date coverage starts for the Subscriber and any enrolled Dependents is the effective date of coverage. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan are not available before the effective date of coverage. Blue Shield will notify you of your effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. California law establishes the open enrollment period each year. Visit blueshieldca.com for more information about open enrollment, including this year's dates.

Special enrollment period

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Triggering Event.

A special enrollment period gives you at least 60 days from a Triggering Event to apply for or change coverage for yourself or your Dependents. See the Special enrollment period section for more information. You should notify Covered California as soon as possible if you experience a Triggering Event that requires a change in your coverage.

If you qualify for a special enrollment period and coverage begins in the middle of a plan year, your coverage under this Agreement will be less than a full year and will end on December 31 of the year coverage began. For a complete list of Triggering Events, see the Special enrollment period section.

Common Triggering Events
Change in Dependents
Move within California under certain circumstances
Loss of minimum essential coverage
Loss of eligibility in a government program

Effective date of coverage for most special enrollment periods

If enrolled during open enrollment, Dependents have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Subscriber submits an application or request for special enrollment, the effective date of coverage will be the 1st of the next month.

Effective date of coverage for a new spouse or Domestic Partner

The effective date of coverage for a new spouse or Domestic Partner will be the 1st of the month following the date the Subscriber submits the Dependent enrollment application. This applies regardless of what day of the month the Subscriber submits the application.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

1. Newborn;
2. Adopted child;
3. Child placed for adoption;
4. Child placed in foster care; or
5. Child for whom the Subscriber, spouse, or Domestic Partner is the court-appointed legal guardian.

This coverage lasts for 31 days.

For coverage to continue beyond 31 days, the Subscriber must enroll the child through Covered California within 60 days of birth, adoption, placement for adoption, placement in foster care, or the date of court-ordered guardianship.

A child will be considered adopted for the purpose of Dependent eligibility when one of the following happens:

1. The child is legally adopted;
2. The child is placed for adoption and there is evidence of the Subscriber, spouse, or Domestic Partner's right to control the child's health care; or
3. The Subscriber, spouse, or Domestic Partner is granted legal authority to control the child's health care.

The child's eligibility as a Dependent will continue while waiting for a legal decree of adoption unless the child is removed from the Subscriber, spouse, or Domestic Partner's home before the decree is issued.

Terms of coverage

The Subscriber's option to renew this coverage is guaranteed, except as the law permits. The Subscriber must pay Premiums in full within the required timeframe, and the Subscriber and Dependents must maintain eligibility.

The Subscriber must notify Covered California within 60 days of any changes that will affect the eligibility of the Subscriber or an enrolled Dependent. Blue Shield is not obligated to pay for Benefits for an ineligible individual, even if the Subscriber continues to pay Premiums for that individual.

Blue Shield has the right to change this plan, as the law permits. This includes changes to:

1. Terms and conditions;
2. Benefits;
3. Premiums; and
4. Limitations and exclusions.

Blue Shield will not change terms and conditions, Benefits, or limitations and exclusions on an individual basis. If Blue Shield changes this Agreement, the change will affect everyone covered under this plan. Blue Shield will give the Subscriber written notice of any changes to the Agreement. We will send this notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal.

Your Premiums may change without written notice when you initiate the type of change described in the Changes to Premiums section.

When coverage ends

Your coverage will end if:

1. The Subscriber cancels or does not renew coverage;
2. Blue Shield or Covered California cancels or does not renew coverage; or
3. Blue Shield or Covered California rescinds coverage.

If the Subscriber pays Premiums beyond the date coverage ends, those Premiums are unearned. Blue Shield will refund unearned Premiums to the Subscriber, minus any amount Blue Shield pays for Benefits received after the date coverage ends. Blue Shield will only issue a refund to the Subscriber if the amount the Subscriber paid in unearned Premiums is more than the amount Blue Shield pays for Benefits after coverage ends.

When Pediatric Coverage Ends

Pediatric Members of this Plan will receive the Pediatric dental Benefits through the end of the month in which the Member turns 19. Upon reaching age 19, unless we receive notice to cancel, the covered Pediatric Member will receive Benefits under the Adult dental Benefits of this Plan until coverage ends.

If the Subscriber cancels or does not renew coverage

The Subscriber can cancel coverage by giving Covered California 14 days' notice. Coverage will end at 11:59 p.m. Pacific Time on the effective date of termination.

If the Subscriber decides to cancel coverage, the actual date coverage ends is based on when the Subscriber gives notice to Covered California. Once the Subscriber's coverage is terminated, coverage under this plan cannot be reinstated. However, you may reapply for coverage during open enrollment, or if you qualify for special enrollment.

When coverage ends if the Subscriber cancels or does not renew	
If the Subscriber gives	***Date coverage ends***
14 days' notice or more	The date the Subscriber selects
Less than 14 days' notice	A date Covered California selects that is at least 14 days after receipt of your notice

If Blue Shield or Covered California cancels or does not renew coverage

Blue Shield or Covered California can cancel coverage or deny renewal, as the law permits. If this happens, the date coverage ends depends on the reason for cancellation or non-renewal.

Cancellation for Subscriber's nonpayment of Premiums

Blue Shield can cancel your coverage if the Subscriber does not pay the required Premiums in full and on time. The Subscriber is responsible for all Premiums during the term of coverage, including the grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send the Notice of Termination to the Subscriber within five business days of the cancellation. This notice will state:

1. That the Agreement has been canceled;
2. The reasons for cancellation; and
3. The specific date and time when your coverage will end.

Cancellation for fraud or intentional misrepresentation of material fact

Blue Shield or Covered California may cancel your coverage for fraud or intentional misrepresentation of material fact if you:

1. Intentionally provide false or misleading information to Blue Shield or Covered California on the enrollment application or otherwise. This includes incorrect or incomplete material information such as failing to provide Blue Shield with required or requested information in a timely manner;
2. Let someone else use your ID card to receive services; or
3. Receive, or attempt to receive, services by means of false, materially misleading, or fraudulent information, acts, or omissions.

Blue Shield or Covered California rescinds coverage

IF THE SUBSCRIBER OR ANY ENROLLED DEPENDENT COMMITS FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT DURING THE APPLICATION PROCESS, BLUE SHIELD OR

COVERED CALIFORNIA CAN RETROACTIVELY CANCEL COVERAGE. THIS INCLUDES FAILURE TO DISCLOSE ANY NEW OR CHANGED FACTS PERTAINING TO THE APPLICATION THAT ARISE AFTER SUBMISSION OF THE APPLICATION BUT BEFORE THE EFFECTIVE DATE OF COVERAGE. THIS RETROACTIVE CANCELLATION IS RESCISSION.

If Blue Shield or Covered California rescinds coverage, Blue Shield will provide the Subscriber with a 30-day written notice. This notice will state:

1. The reason for the rescission;
2. Information about the Subscriber's right to appeal, including the right to request assistance from the Department of Managed Health Care;
3. Clarification that individuals whose application information was not false or incomplete are entitled to new coverage, and:
   a) How those individuals may obtain new coverage; and
   b) How Blue Shield will determine Premiums for those individuals.

After your contract has been in effect for 24 months, Blue Shield or Covered California cannot rescind coverage for any reason. If Blue Shield or Covered California rescinds coverage, the Subscriber and any enrolled Dependents will lose all coverage dating back to the original effective date of coverage. It will be as if coverage never existed.

When Blue Shield or Covered California cancels, does not renew, or rescinds coverage	
Reason	***Date coverage ends***
Failure to pay Premiums in full and on time, including the grace period	30 days after the date on the Notice of Start of Grace Period
Fraud or intentional misrepresentation of a material fact during the application process	The initial effective date of coverage
Fraud or intentional misrepresentation of a material fact after enrollment	30 days after written notice to the Subscriber
Loss of Subscriber eligibility	30 days after written notice to the Subscriber
Loss of Dependent eligibility for a spouse or Domestic Partner	If notice of ineligibility is sent before the 15th of the month: The first day of the month after notice is sent If notice of ineligibility is sent after the 15th of the month: The first day of the second month after notice is sent
Loss of Dependent eligibility for a child	The last day of the year in which the Dependent turns 26
Subscriber changes from one health plan to another during open or special enrollment period	The day before the effective date of coverage in the Subscriber's new plan
Request to enroll a newborn, adopted child, or child placed for adoption is not received within 60 days of the initial coverage date	Day 31 following the initial coverage date
Blue Shield no longer offers this Individual and Family Plan	90 days after written notice to the Subscriber
Blue Shield no longer offers any Individual and Family Plans	180 days after written notice to the Subscriber
Subscriber was enrolled in a Qualified Dental Plan without his or her knowledge or consent by a third party, including by a third party with no connection to Covered California	The initial effective date of coverage

Duration of the Agreement

This Agreement shall be renewed upon receipt of prepaid Premiums unless otherwise terminated as described herein. Renewal is subject to Blue Shield of California's right to amend this Agreement. Any change in Premiums or Benefits, are effective after 60 days' notice to the Subscriber's address of record with Blue Shield of California.

This Agreement has a benefit year that runs for the Calendar Year. Subscribers and their Dependents will have an annual Open Enrollment Period established each year by California law to select a different or new plan. Covered California will give notice of the annual Open Enrollment Period.

Blue Shield will offer to renew the Agreement except in the following instances:

1) Non-payment of Premiums;
2) Fraud, misrepresentations, or omissions;
3) Termination of plan type by Blue Shield;

4) Covered California determines that the individual is no longer eligible for coverage in a Qualified Dental Plan (QDP); or
5) Subscriber relocates outside of California.

Premiums

Monthly Premiums are as stated in the Appendix. Blue Shield of California offers a variety of options and methods by which you may pay your Premiums. Please contact Member Service at 1-877-885-0254 to discuss these options or visit the Blue Shield of California internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield of California
P.O. Box 4700
Whittier, CA 90607-4700

Changes to Premiums

Blue Shield may change your Premium as the law permits. Blue Shield can change your Premium if:

1. A federal, state, or other taxing or licensing authority imposes a tax or fee;
2. Blue Shield's federal income tax associated with federal excise tax increases;
3. Federal or state law requires it; or
4. You relocate to a different geographic rating region.

Premiums may vary due to differences in the cost of health care services within each geographic rating region.

Blue Shield will give the Subscriber written notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal, of any Premium change.

Your Premiums may change without written notice when:

You move to a new geographic rating region. Your new Premium is effective the first of the month after your last billing cycle.

You add or drop a Dependent. For more information about changing Dependents, see the Enrollment and effective dates of coverage section.

Service Area

The Service Area of this Plan is identified in the Plan Dental Directory. Within the Service Area, Members will be entitled to receive all Covered Services specified in the Summary of Benefits and the Dental Schedule and Limitations table below. The Plan will not pay for Dental Care Services that are (a) not Covered Services, (b) not provided by, or referred and authorized by the Member's Dental Provider, and/or (c) not referred and authorized by the Plan, where applicable. The Member will be required to pay for the cost of such services received.

Within the Service Area, Members should contact their assigned Dental Provider for Emergency Services. Out-of-area Emergency Services are covered by the Plan subject to some limitations, as described in the section entitled "Choice of Dental Provider".

Timely Access to Dental Care Services

Blue Shield provides the following guidelines for timely access to care from Dental Providers:

Service	Access to Care
Urgent Care	Within 72 hours
Non-urgent care	Within 30 business days
Preventive dental care	Within 40 business days

Note: For availability of interpreter services at the time of the Member's appointment, contact customer service at the number shown in the "Dental Customer Service" section of this booklet. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this Evidence of Coverage.

Choice of Dental Provider

Selecting a Dental Provider

A close Dentist - patient relationship is an important element that helps to ensure the best dental care. Each family is therefore required to select a Dental Provider at the time of enrollment. This decision is an important one because your Dental Provider will:

1. Help you decide on actions to maintain and improve your dental health.
2. Provide, coordinate and direct all necessary covered Dental Care Services.
3. Arrange referrals to Plan Specialists when required, including the prior authorization you will need.
4. Authorize Emergency Services when appropriate. Refer to the Emergency Services section for more information.

The Dental Provider for each Subscriber must be located sufficiently close to the Subscriber's home or work address to ensure reasonable access to care, as determined by the Plan.

A Dental Provider must also be selected for a newborn or child placed for adoption if a covered Dependent.

If you do not select a Dental Provider at the time of enrollment or seek assistance from the Dental Plan Member Services Department within 15 days of the effective date of coverage, the Plan will designate a temporary Dental Provider for you and your Dependents, and notify you of the designated Dental Provider. This designation will remain in effect until you advise the Plan of your selection of a different Dental Provider.

The Member should contact Dental Plan Member Services if they need assistance locating a Dental Provider in the Service Area. Blue Shield will review and consider the request for services that cannot be reasonably obtained in network. If the request for services from a Non-Participating Dentist is approved, the Member will be responsible for the Copayments related to Covered Services. Blue Shield will pay the amount billed for Covered Services (less Member Copayment) from the Non-Participating Dentist. Without this approval, the Member will be responsible for paying the Non-Participating Dentist directly for the entire amount billed by the Dentist.

Changing Dental Providers

The Member may change Dental Providers without cause at the following times:

1. During Open Enrollment;
2. When your change in residence or work address makes it inconvenient to continue with the same Dental Provider;
3. One (1) other time during the Calendar Year.

If you want to change Dental Providers at any of the above times, you may call Dental Member Services at 1-877-885-0254. Before changing Dental Providers you must pay any outstanding Copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.

If your Dental Provider ceases to be in a contracted Dental Plan Administrator's Provider Network, the Plan will notify you in writing. To ensure continuity of care you will temporarily be assigned to an alternate Dental Provider and you will be asked to select a new Dental Provider. If you do not select a new Dental Provider within the specified time, your alternate Dental Provider assignment will remain in effect until you notify the Plan of your desire to select a new Dental Provider.

Coordination of Benefits

All individual and family medical plans include an embedded Pediatric dental Benefit on the health benefits exchange. For purposes of coordinating Pediatric Benefits the medical plan is the primary dental Benefit plan and the Family Dental HMO Plan Plan is the secondary dental Benefit plan.

Continuity of Care by a Terminated Provider

Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received Authorization from a now-terminated provider for dental surgery, or another dental procedure as part of a documented course of treatment, can request completion of care in certain situations with a provider who is leaving a contracted Dental Plan Administrator's Participating Dentist Network. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received Authorization from a provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

Payment of Providers

Blue Shield contracts with a Dental Plan Administrator to provide services to our Members. A monthly fee is paid to a contracted Dental Plan Administrator for each Member. This payment system includes incentives to a contracted Dental Plan Administrator to manage all Covered Services provided to Members in an appropriate manner consistent with this contract. If you want to know more about this payment system, contact Dental Plan Member Services at 1-877-885-0254 or talk to your Participating Dentist.

A contracted Dental Plan Administrator is responsible for providing Covered Services and/or referring the Member to Plan Specialists and Participating Dentists. Your Dental Provider must obtain Authorization from a contracted Dental Plan Administrator before referring you to providers outside of the Dental Center.

Relationship with Your Dental Provider

The Dentist - patient relationship you establish with your Dental Provider is very important. The best effort of your Dental Provider will be used to ensure that all Medically Necessary and appropriate professional services are provided to you in a manner compatible with your wishes.

If your Dentist recommends procedures or treatment, which you refuse, or you and the Dental Provider fail to establish a satisfactory relationship, you may select a different Dental Provider. The Plan Member Services can assist you with this selection.

Your Dental Provider will advise you if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, the Plan Member Services will assist you in the selection of another Dental Provider.

Repeated failures to establish a satisfactory relationship with a Dental Provider may result in termination of your coverage, but only after you have been given access to other available Dental Providers and have been unsuccessful in establishing a satisfactory relationship. Any such termination will take place

in accordance with written procedures established by Blue Shield and only after written notice to the Member which describes the unacceptable conduct, provides the Member with an opportunity to respond and warns the Member of the possibility of termination.

How to Use Your Dental Plan

Use of Dental Provider

At the time of enrollment, you will choose a Dental Provider that will provide and coordinate all covered dental services. You must contact your Dental Provider for all dental care needs including preventive services, routine dental problems, consultation with Plan Specialists, and Emergency Services. The Dental Provider is responsible for providing general Dental Care Services and coordinating or arranging for referral to other necessary Plan Specialists. The Plan must authorize such referrals.

To avoid a broken appointment charge, you must always cancel any scheduled appointments at least 24 hours in advance. Charges are listed in the section entitled “Summary of Benefits” and on the Dental Schedule and Limitations Table.

If the Member needs help finding a Participating Dentist who can provide care close to home, the Member should call Member Services. If a Participating Dentist is not available, the Member can ask to see a Non-Participating Dentist at the Participating Dentist Cost Share. If the services cannot reasonably be obtained from a Participating Dentist, the Plan will approve the request and the Member will only be responsible for the Participating Dentist Cost Share.

To obtain Benefits under your Plan, you must attend the Dental Provider you selected or was designated for you. If for any reason you did not select a Dental Provider, contact your dental Member Services at: 1-877-885-0254.

Waiting Period

There is no waiting period for this Plan.

Referral to Plan Specialists

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of specialty service needed is not available within your Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and you will then be able to schedule an appointment with the specialist. When no Participating Dentist is available to perform the needed service, the Dental Provider will refer you to a Non-Participating Dentist after obtaining Authorization from a contracted Dental Plan Administrator. This Authorization procedure is handled for you by your Dental Provider.

Generally, your Dental Provider will refer you within the network of Blue Shield Plan Specialists in your area. After the specialty services have been rendered, the Plan Specialist will provide a complete report to your Dental Provider to ensure your dental record is complete.

Emergency Services

A dental emergency means, “an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the Member’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the member to undue suffering.”

For Emergency Services within your Service Area you should first notify your Dental Provider to obtain care, Authorization, or instructions for care prior to actual emergency treatment. If it is not possible to notify your Dental Provider prior to receiving Emergency Services, you must notify your Dental Provider within 24 hours after care is received unless it was not reasonably possible to communicate within this time limit. In such case, notice must be given as soon as possible. Failure to provide notice as stated may result in the services not being covered.

If you are in need of emergency treatment and are outside the geographic area of your designated Dental Provider, you should first contact a contracted Dental Plan Administrator to describe the emergency and receive referral instructions. If a contracted Dental Plan Administrator does not have a contracted Dentist in the area, or if you are unable to contact a contracted Dental Plan Administrator, you should contact a Dentist of your choice. You will be directly reimbursed for this treatment up to the maximum allowed under your Plan Benefits. Refer to the section titled “Responsibility for Copayments, Charges for non-Covered Services and Emergency Claims” within the insert.

NOTE: A contracted Dental Plan Administrator will respond to all requests for prior Authorization of services as follows:

1. for urgent services, as soon as possible to accommodate the Member’s condition not to exceed 72 hours from receipt of the request;
2. for other services, within 5 business days from receipt of the request.

If you obtain services without prior Authorization from a contracted Dental Plan Administrator, a Dental Plan Administrator will retrospectively review the services for coverage as Emergency Services. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, you will be responsible for the entire

cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Out-of-Area Benefits

If a Member receives Emergency Services outside the Service Area, the Member shall be entitled to reimbursement of up to $50 per occurrence for such Covered Dental Services. Whenever possible, the Member should ask the provider to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Member will be made after a contracted Dental Plan Administrator receives documentation of the charges incurred and upon approval by a contracted Dental Plan Administrator of those charges set forth. Except for Emergency Services, as noted above, a Member will be responsible for full payment of dental services rendered outside the Service Area.

In-Area Benefits (Those received within the Service Area)

Palliative Treatment received in an emergency from a Non-Participating Dentist will be covered according to the Summary of Benefits and the Dental Schedule and Limitations Table, if the Member has attempted but failed to reach his or her designated Dentist during the emergency.

If the Member receives Emergency Services from a Non-Participating Dentist, a contracted Dental Plan Administrator will retrospectively review the services provided. If a contracted Dental Plan Administrator determines that the situation did not require Emergency Services, the Member will be responsible for the entire cost of the services. A contracted Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Limitation of Member Liability

When a Participating Dentist renders Covered Services, the Member is responsible only for the applicable Copayments. Members are responsible for the full charges for any non-Covered Services they obtain.

If your provider ceases to be a Participating Dentist, you will be notified in writing if you are affected. The provider is required to complete any work in progress, after which you must select a new provider. Once provisions have been made for the transfer of your care, services of a former Participating Dentist are no longer covered, except as provided for in the sections entitled “Choice of Dental Provider” and “Continuity of Care by a Terminated Provider”.

You will not be responsible for payment, other than Copayments, to a former Participating Dentist for any Covered Services you receive prior to the effective date of the transfer to a new Dental Provider.

Plan Benefits

The Benefits available to you under the Plan are listed in the Summary of Benefits and on the Dental Schedule and Limitations Table. The Copayments for these services, if applicable, are also listed in the Summary of Benefits and on the Dental Schedule and Limitations Table.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide Dental Care Services and is operating within the scope of that license or certification.

Telehealth Services

This Plan covers services appropriately delivered by any Dentist remotely via communications technologies on the same basis and to the same extent as the same in-person services.

Important Information

The Dental Care Services described in this booklet are covered only if they are Medically Necessary and are provided, prescribed, or referred by your Dental Provider and are approved by a contracted Dental Plan Administrator. Coverage for these services is subject to all terms, conditions, limitations, and exclusions of this Agreement, and to the general exclusions and limitations set forth in the section entitled “General Exclusions and Limitations”. A contracted Dental Plan Administrator will not pay charges incurred for services without your Dental Provider’s and/or a contracted Dental Plan Administrator’s prior Authorization except for Emergency Services obtained in accordance with the section entitled “How to Use Your Dental Plan”.

The determination of whether services are Medically Necessary or are an emergency will be made by a contracted Dental Plan Administrator. This determination will be based upon the Plan's review consistent with generally accepted dental standards, and will be subject to appeal in accordance with the procedures outlined in the section entitled “Member Services and Grievance Process”.

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for Covered Services provided under the Plan.

Accrual Balance

You can check your accrual balances toward your Calendar Year Deductible and Maximum Calendar Year Benefit at any time by logging into your member portal online, which is updated daily, or calling Customer Service at the number on the back of your ID card. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services. Your accrual balances will also be included on the explanation of Benefits you receive once a claim has been processed.

General Provisions

Claims and Services Review

Blue Shield and a Dental Plan Administrator reserve the right to review all claims and services to determine if any exclusion or other limitations apply. Blue Shield or a Dental Plan Administrator may use the services of Dentist consultants, peer review committees of professional societies and other consultants to evaluate claims.

Participating Dentist Network

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

A Dental Plan Administrator has established a network of Dental Providers and other dental health professionals in your Service Area.

The Dental Provider(s) you and your Dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of necessary Dental Care Services. The Directory of Dental Providers in your Service Area indicates their location and phone numbers. The list is subject to change without notice.

Please contact your dental Member Services or your selected provider to verify his or her participation.

Independent Contractors

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall Blue Shield of California be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any Dentist, physician, hospital, or other provider or their employees.

Responsibility for Copayments, Charges for Non-Covered Services, and Emergency Claims

Member Responsibility

The Member shall be responsible to the Dental Provider and other Participating Dentist for payment of the following charges:

1. Any amounts listed under Copayments in the preceding Summary of Benefits and on the Dental Schedule and Limitations Table.
2. Any charges for non-Covered Services.

All such Copayments and charges for non-Covered Services are due and payable to the Dental Provider or Participating Dentists immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Dental Provider or other Participating Dentist for any such Copayments or charges owing.

Elective Treatment for Non-Covered Services

When the Member and Dentist opt to select a procedure that is more expensive than the covered Benefit, the Member will be responsible for the Copayment of the covered Benefit plus the difference between the Dentist's billed charges for the Covered Service and the selected procedure. If no dental service appearing on the Summary of Benefits or on the Dental Schedule and Limitations Table is related to the procedure selected, the service is excluded as listed in the section entitled “General Exclusions”. In all instances, Benefits will be provided for Medically Necessary restoration of tooth structure.

Emergency Claims

If Emergency Services outside of the Service Area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Service record (a copy of the Dentist’s bill) for payment to a Plan Administrator, within 1 year after the treatment date.

Please send this information to:

Blue Shield of California

P.O. Box 30567

Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, a Dental Plan Administrator will review the claim retrospectively. If a Dental Plan Administrator determines that the services were not Emergency Services and would not otherwise have been authorized by a Dental Plan Administrator, and therefore, are not Covered Services under this Agreement, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with a Dental Plan Administrator’s decision, the Member may appeal using the procedures outlined in the section entitled “Member Services and Grievance Process”.

Blue Shield Online

Blue Shield’s internet site is located at http://www.blueshieldca.com. Members using a personal computer and modem with World Wide Web access may view and download dental information and software.

General Exclusions and Limitations

If you have questions about limitations and exclusions for specific dental procedures, please contact Dental Customer Service at the number at the end of this booklet.

Adult and Pediatric General Exclusions

Unless otherwise specifically mentioned elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Services of Dentists or other practitioners of healing arts not associated with the Dental Service Plan, except upon referral arranged by a Dental Provider and authorized by the Plan or when required in a covered emergency;
2. Any service, procedure, or supply which is received or expenses incurred prior to the Member's effective date of coverage. For the purpose of this exclusion, the date on which a procedure shall be considered to have had expenses incurred is defined as follows:

   a) For full dentures or partial dentures: on the date the final impression is taken,

   b) For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared,

   c) For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex,

   d) For periodontal surgery: on the date the surgery is actually performed,

   e) For all other services: on the date the service is performed.

   This exclusion does not apply to Covered Services to treat complications arising from services received prior to Member's effective date of coverage;
3. Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage or on the Dental Schedule and Limitations Table below;
4. Dental services performed in a hospital or any related hospital fee;
5. Any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
6. Cosmetic procedures including, but not limited to, bleaching, veneer facings, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures;
7. Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
8. Congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as Orthognathic surgery, including Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging;
9. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
10. Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
11. Treatment for which payment is made by any governmental agency, including any foreign government;
12. General anesthesia, including intravenous and inhalation sedation, except when of Medical Necessity.

    General anesthesia is considered Medically Necessary when its use is:

    a. In accordance with generally accepted professional standards;
    b. Not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; and
    c. Due to the existence of a specific medical condition.

    Written documentation of the medical condition necessitating use of general anesthesia or intravenous sedation must be provided by a physician (M.D.) to the Dental Provider and approved by a Dental Plan Administrator.

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    Mental disability is an acceptable medical condition to justify use of general anesthesia.

    The Plan reserves the right to review the use of general anesthesia to determine Medical Necessity.
13. Precious metals (if used, will be charged to the patient at the Dentist's cost);
14. Charges for second opinions, unless previously authorized by a Dental Plan Administrator;
15. Services provided to Members by out-of-network Dentists unless preauthorized by the company, except when immediate dental treatment is required as a result of a dental emergency;

16. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
17. Replacement of lost, missing, stolen or damaged or prosthetic device;
18. House calls for dental services;
19. All prescription and non-prescription drugs;
20. Any dental services received subsequent to the time the Member's coverage ends;
21. Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
22. Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member; and
23. Dental Care Services administered by a Pediatric Dentist, except when:
    a) The Member child's primary Dental Provider is a pediatric Dentist; or
    b) The Member child is referred to a pediatric Dentist by the primary Dental Provider.

Adult General Exclusions

Unless otherwise specifically mentioned elsewhere under this Plan, this Plan does not provide Adult Benefits with respect to:

1. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a Dental Plan Administrator and its dental consultants;
2. Reimbursement to the Member or another dental office for the cost of services secured from Dentists, other than the Dental Provider or other Participating Dentist, except:
    a. When such reimbursement is expressly authorized by the Plan; or
    b. As cited under the Emergency Services and Emergency Claims provisions;
3. Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
4. Removal of 3rd molar (wisdom teeth) other than for Medical Necessity. Medical Necessity pertaining to the removal of 3rd molar (wisdom teeth) is defined as a pathological condition which includes horizontal, mesial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not Medically Necessary;
5. Diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint;
6. Bone grafting done for socket preservation after tooth extraction or in preparation for Implants;
7. Dental Implants (surgical insertion and/or removal), transplants, ridge augmentations, or socket preservation, and any appliance and/or crowns attached to Implants;
8. Services of prosthodontists;
9. Services of orthodontists;
10. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;
11. Services arising from voluntary self-inflicted injury whether the patient is sane or insane;
12. Training and/or appliances to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
13. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
14. Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
15. Replacement of existing crown, bridges, or dentures that are less than five (5) years old;
16. Charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed;
17. Duplicate dentures, prosthetic devices or any other duplicate appliance; and
18. Any and all Implant services that have not been prior authorized and approved by a Dental Plan Administrator. Implants that are used as an abutment, double abutment, or bone anchor to support or hold a fixed bridge, orthodontic appliance, removable prosthesis, or oral-maxillofacial prosthesis are not covered.

Adult General Limitations

The following services, if listed on the Summary of Benefits or on the Dental Schedule and Limitations Table, will be subject to limitations as set forth below:

1. Referral to a specialty care Dentist is limited to Oral Surgery, Periodontics, Endodontics and pediatrics;
2. Oral Surgery services are limited to removal of teeth, bony protuberances and frenectomy.
3. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the Dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than three (3) teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.
4. General or IV sedation is covered for:
   a) Three (3) or more surgical extractions;
   b) Any number of Medically Necessary impactions;
   c) Full mouth or arch alveoloplasty;
   d) Surgical root recovery from sinus;
   e) Medical problem contraindicates local anesthesia.
   f) General or IV sedation is not a covered Benefit for dental-phobic reasons. General or IV sedation is covered for up to thirty minutes per visit;
5. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
6. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bounded spaces;and
7. Cone Beam CT (D0367) is a benefit only when placing an Implant. This procedure cannot be used for Orthodontics or Periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only.

Pediatric Preventive Exclusions and Limitations (D1000-D1999)

1. Fluoride treatment (D1206 and D1208) is a Benefit only for prescription strength fluoride products;
2. Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and
3. The application of fluoride is only a Benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

Pediatric Restorative Exclusions and Limitations (D2000-D2999)

1. Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
2. Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
3. Restorations for primary teeth near exfoliation;
4. Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription;
5. Prefabricated crowns for primary teeth near exfoliation;
6. Prefabricated crowns are not a Benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214);
7. Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
8. Prefabricated crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
9. Prefabricated crowns are not a Benefit when a tooth can be restored with an amalgam or resin-based composite restoration;
10. Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
11. Laboratory crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and
12. Laboratory processed crowns are not a Benefit when the tooth can be restored with an amalgam or resin-based composite.

Pediatric Endodontic Exclusions and Limitations (D3000-D3999)

1. Endodontic procedures when the prognosis of the tooth is questionable due to non- restorability or periodontal involvement;

2. Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and
3. Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Pediatric Periodontal Exclusions and Limitations (D4000-D4999)

1. Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

Pediatric Prosthodontic (Removable) Exclusions and Limitations (D5000-D5899)

1. Prosthodontic services provided solely for cosmetic purposes;
2. Temporary or interim dentures to be used while a permanent denture is being constructed;
3. Spare or backup dentures;
4. Evaluation of a denture on a maintenance basis;
5. Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a Benefit;
6. Partial dentures are not a Benefit to replace missing 3rd molars;
7. Laboratory relines (D5760 and D5761) are not a Benefit for resin based partial dentures (D5211and D5212);
8. Laboratory relines (D5750, D5751, D5760 and D5761) are not a Benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741);
9. Chairside relines (D5730, D5731, D5740 and D5741) are not a Benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761);
10. Tissue conditioning (D5850 and D5851) is only a Benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment; and
11. Tissue conditioning (D5850 and D5851) is a Benefit the same date of service as an immediate prosthesis that required extractions.

Pediatric Implant Exclusions and Limitations (D6000-D6199)

1. Implant services are a Benefit only when exceptional medical conditions are documented and the services are considered Medically Necessary; and
2. Single tooth implants are not a Benefit.

Pediatric Prosthodontic (Fixed) Exclusions and Limitations (D6200-D6999)

1. Fixed partial dentures (bridgework) are not a Benefit; however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture;
2. Fixed partial dentures are not a Benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;
3. 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 Member's masticatory ability;
4. Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and
5. Cast resin bonded fixed partial dentures (Maryland Bridges).

Pediatric Oral and Maxillofacial Surgery Exclusions and Limitations (D7000-D7999)

1. The prophylactic extraction of 3rd molars is not a Benefit;
2. TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a Benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation;
3. TMJ dysfunction procedures solely for the treatment of bruxism is not a Benefit; and
4. Suture procedures (D7910, D7911 and D7912) are not a Benefit for the closure of surgical incisions.

Pediatric Orthodontic Exclusions and Limitations

Orthodontic procedures are covered when Medically Necessary to treat handicapping malocclusion, cleft palate, or facial growth management cases for Members under the age of 19, when prior authorization is obtained.

Medically Necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. Initial orthodontic examination (D0140) called the Limited Oral Evaluation must be conducted. This examination includes completion and submission of the completed HLD

Score Sheet with the Specialty Referral Request Form. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for Medically Necessary orthodontic services.

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.

Those immediate qualifying conditions are:

1. Cleft lip and or palate deformities.
2. Craniofacial Anomalies including the following:
   - Crouzon's syndrome,
   - Treacher-Collins syndrome,
   - Pierre-Robin syndrome,
   - Hemi-facial atrophy, Hemfacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a Benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.
6. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

   The remaining conditions must score 26 or more to qualify (based on the HDL Index).

Excluded are the following conditions:

- Crowded dentitions (crooked teeth)
- Excessive spacing between teeth
- Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies
- Treatment in progress prior to the effective date of this coverage.
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Medical Necessity Exclusion

All services must be Medically Necessary. The fact that a Dentist or other Participating Dentist may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity. Even though it is not specifically listed as an exclusion or limitation, Blue Shield may limit or exclude Benefits for services which are not Medically Necessary.

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the Dental Service Plan will pay Benefits based upon the less costly service.

Other Provisions

Exception for Other Coverage

A Participating Dentist may seek reimbursement from other third-party payers for the balance of its reasonable charges for services rendered under this Plan.

Reductions - Third Party Liability

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield or a contracted Dental Plan Administrator shall, with respect to services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or

third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:

1. Notify Blue Shield or a contracted Dental Plan Administrator in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and a contracted Dental Plan Administrator, in writing, within ten (10) days after any Recovery has been obtained.

A Member's failure to comply with 1 through 5 above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield or a contracted Dental Plan Administrator.

Limitations for Duplicate Coverage

Medicare

If you receive Medicare, Blue Shield will provide your Benefits, but Medicare will typically be the primary payor and Blue Shield will be the secondary payor as determined by Medicare regulations.

When Blue Shield is the secondary payor, your combined Benefits from Medicare and Blue Shield will equal but not exceed what Blue Shield would pay if you were not eligible for Medicare. Blue Shield's payment will be based on an amount that may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You must pay any applicable Deductibles, Copayments, and Coinsurance for your Blue Shield plan before Blue Shield will provide Benefits.

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, Blue Shield will pay the reasonable value or the Allowable Amount for Covered Services you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or the Allowable Amount for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and Blue Shield will equal but not be more than what Blue Shield would pay if you were not eligible for Benefits under that coverage. Blue Shield will provide Benefits based on the reasonable value or the Allowable Amount.

Entire Agreement: Changes

This Agreement, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire Agreement. Any statement made by the Member shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by a corporate officer of Blue Shield and unless a written endorsement is issued. No representative has authority to change this Agreement or to waive any of its provisions.

Benefits, such as Covered Services, Calendar Year Benefits, Deductible, Copayment, or maximum per Member and family Calendar Year Copayment/Coinsurance responsibility amounts are subject to change at any time. Blue Shield of California will provide at least 60 days written notice of any such changes.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain Benefits.

Special Enrollment Period

A special enrollment period is a timeframe outside of open enrollment when a Qualified Individual can enroll in, or change enrollment in, a health plan. The special enrollment period is 60 days following the date of a Triggering Event, unless a different period is specified below. When the loss of minimum essential coverage is anticipated, a

special enrollment period also precedes the Triggering Event. The following are Triggering Events:

1. Loss of minimum essential coverage for a reason other than:
   a) Failure to pay premiums on a timely basis (including Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or Cal-COBRA premiums);
   b) A situation that would allow a rescission, such as an intentional misrepresentation of a material fact on the application for coverage; or
   c) Other loss of coverage due to the fault of the enrollee. Additional 60-day period before Triggering Event applies.
2. Loss or anticipated loss of coverage under an employer-sponsored health plan as a result of:
   a) With respect to the Subscriber:
      i. The termination of employment (other than through gross misconduct); or
      ii. The reduction of hours of employment to less than the number of hours required for eligibility.
   b) With respect to the spouse, Domestic Partner and Dependent children:
      i. The death of the Subscriber;
      ii. The termination of the Subscriber's employment (other than through the Subscriber's gross misconduct);
      iii. The reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility;
      iv. The divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership;
      v. The Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare");
      vi. A Dependent child's loss of Dependent status under the generally applicable requirements of the plan; or
      vii. The employer files for reorganization under Title XI of the United States Code, commencing on or after July 1, 1986 (COBRA only - when the Subscriber is covered as a retiree).
   c) Discontinuation of the employer's contribution toward Subscriber or Dependent coverage.
   d) Exhaustion of COBRA or Cal-COBRA continuation coverage or complete loss of employer premium contributions or governmental subsidies.
3. Loss of Medi-Cal coverage for pregnancy-related services, loss of access to CHIP unborn child coverage due to the birth of the child, or loss of CHIP coverage. The special enrollment period begins 60 days before the Triggering Event and ends 90 days after the Triggering Event.
4. Loss of Medi-Cal medically needy coverage (only once per calendar year). The special enrollment period begins 60 days before the Triggering Event and ends 90 days after the Triggering Event.
5. Acquiring or becoming a Dependent through marriage, establishment of domestic partnership, birth, adoption, placement for adoption, placement in foster care or through a child support order or other court order.
   a) If a parent is required to provide health insurance coverage for a child, and enrollment is requested by the Subscriber parent or upon presentation of a court order or request by the non-Subscriber parent, the local child support agency, or person having custody of the child, or the Medi–Cal program.
6. A Qualified Individual's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of Blue Shield, Covered California, or the Department of Health and Human Services (HHS), evaluated and determined by Covered California. In such cases the action may be taken to correct or eliminate the effects of such error, misrepresentation, or inaction.
7. A Qualified Individual or Dependent demonstrates that they did not enroll in a health plan during the immediately preceding enrollment period available to the individual because they were misinformed that they were covered under minimum essential coverage.
8. A Qualified Individual or Dependent demonstrates that the health plan in which they are enrolled substantially violated a material provision of its contract in relation to the Qualified Individual or Dependent.
9. A Qualified Individual or Dependent gains access to a new health plans as a result of a permanent move.
10. A Qualified Individual or Dependent is determined newly eligible for advance payments of the premium tax credit or for cost-sharing reductions. Additional 60-day period before Triggering Event applies.
11. A Qualified Individual or Dependent is determined newly ineligible for advance payments of the premium tax credit or for cost-sharing reductions.
12. A Qualified Individual or Dependent has been released from incarceration.
13. A Qualified Individual is a victim of domestic abuse or spousal abandonment, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic

abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

14. A Qualified Individual or Dependent:
    a) Applies for coverage from Covered California during the annual open enrollment period or due to a Triggering Event, is assessed by the exchange as potentially eligible for Medi-Cal, and is determined ineligible for Medi-Cal either after open enrollment has ended or more than 60 days after the Triggering Event; or
    b) Applies for Medi-Cal during the annual open enrollment period and is determined ineligible after open enrollment has ended.
15. A Qualified Individual or Dependent was receiving services from a contracting provider under another health plan for one of the conditions eligible for completion of Covered Services and that provider is no longer participating in the other health plan.
16. A Qualified Individual or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
17. A Qualified Individual or Dependent is enrolled in an eligible employer-sponsored plan that will no longer be affordable or provide minimum value.
18. A Qualified Individual or Dependent gains access to and enrolls in a qualified small employer health reimbursement arrangement (QSEHRA) or an individual coverage health reimbursement arrangement (ICHRA).
    a) The special enrollment period is 60 days before the Triggering Event if the Qualified Individual receives a written notice of eligibility from the QSHRA or ICHRA at least 90 days before the beginning of the QSHRA or ICHRA plan year.
    b) The special enrollment period is 60 days before or after the Triggering Event if the Qualified Individual does not receive a written notice of eligibility from the QSEHRA or ICHRA at least 90 days before the beginning of the QSHRA or ICHRA plan year.
19. A Qualified Individual or Dependent is enrolled in a Qualified Dental Plan that is decertified.
20. An individual or Dependent is deemed a Qualified Individual because he or she is no longer incarcerated or considered a non-resident.
21. A Qualified Individual or Dependent demonstrates to the exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the exchange may allow.
22. In the case of coverage offered through an HMO, or other network arrangement, that does not provide benefits to individuals who no longer reside, live, or work in a service area.
    a) Individual plan: loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual).
    b) Group plan: loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual and no other benefit package is available to the individual).
    c) A situation in which a Qualified Dental Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
23. National public health emergency or pandemic that results in a declaration of state of emergency at the state or national level.

Grace Period

After payment of the first Premiums, the Subscriber is entitled to a grace period of 30 days for the payment of any Premiums due. During this grace period, the Agreement will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Agreement continues in force.

Time Limit on Certain Defenses

After a Member has been covered under this Agreement for two (2) consecutive years, Blue Shield of California will not use any omission, misrepresentation, or inaccuracy made by the applicant in an individual application to limit, cancel or rescind an Agreement, deny a claim, or raise Premiums.

Legal Actions

No action at law in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of 3 years after the time written proof of claim is required to be furnished.

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference is the Appendix pertaining to Premiums and any endorsements (amendments to this Agreement) that, from time to time, may be issued. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Member may be mailed to the most current address appearing on the records of Blue Shield of California. Notice to Blue Shield may be mailed to:

Blue Shield of California

601 12th Street

Oakland, CA 94607

Commencement or Termination of Coverage

Whether this Agreement may provide for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of the commencement date and as of 11:59 P.M. Pacific Time of the termination date.

Membership Identification Cards

Blue Shield will issue membership identification cards to all Subscribers.

Statutory Requirements

This Agreement is subject to the Knox-Keene Act, Health Care Service Plan Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

Legal Process

Legal process or service must be served upon a corporate officer of Blue Shield of California.

Non-Assignability

Neither the coverage nor any Benefits of this Agreement may be assigned.

Blue Cross and Blue Shield Association Disclosure

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Agreement.

Member Services and Grievance Process

Member Services

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your dental Member Services Department at:

1-877-885-0254

Member Services can answer many questions over the telephone.

You may write to:

Blue Shield of California
Dental Plan Administrator
425 Market St., 15th Floor
San Francisco, CA 94105

Note: A Dental Plan Administrator has established a procedure for our Members to request an expedited decision. A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. A Dental Plan Administrator shall make a decision and notify the Member and physician within 72 hours following the receipt of the request. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Dental Member Services Department at the number listed above.

Grievance Process

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Services Department by telephone, letter, or on-line to request a review of an initial determination concerning a claim or Service. Members may contact the Dental Member Services Department at the telephone number noted below. If the telephone inquiry to the Dental Member Services Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member Services Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the Dental Member Services Department. If the Member wishes, the Dental Member Services staff will assist in completing the grievance form. Completed griev-

ance forms must be mailed to a contracted Dental Plan Administrator at the address provided below. The Member may also submit the grievance to the Dental Member Services Department on-line by visiting http://www.blueshieldca.com.

1-888-271-4880
Blue Shield of California
Dental Plan Administrator
Attn: Dental Appeals/Grievances
P.O. Box 30545
Salt Lake City, UT 84130-0545

A Dental Plan Administrator will acknowledge receipt of a written grievance within 5 calendar days. Grievances are resolved within 30 calendar days.

The grievance system allows Members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

California Department of Managed Health Care 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 **1-888-271-4880** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in Nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **(www.dmhc.ca.gov)** has complaint forms, IMR application forms and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to reasons of health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

Confidentiality of Personal and Health Information

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services at the number listed in the back of this booklet, or by accessing Blue Shield of California's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Free Telephone:
1-888-266-8080

Email Address:
BlueShieldca_Privacy@blueshieldca.com

Notice about Confidential Communication Requests

A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider

name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to blueshieldca.com/privacy and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

Mail: Blue Shield of California Privacy Office, P.O. Box 272540, Chico CA, 95927-2540

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries, or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide Dental Care Services to them, their families, and the public (California Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone Number: 1-510-607-2065

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter;
2. Your name, address, phone number, Subscriber number and group number should be included with each communication;
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter;
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

Definitions

Terms used throughout this Evidence of Coverage are defined as follows:

Adult – Member 19 years of age and older.

Agreement (Evidence of Coverage and Health Service Agreement) — Evidence of Coverage and Health Service Agreement, Summary of Benefits, all endorsements, appendices, and all applications and forms for coverage.

Allowable Amount – a Dental Plan Administrator Allowance (as defined below) for the service (or services) rendered, or the provider's billed charge, whichever is less. A Dental Plan Administrator allowance is:

1. the amount a Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as

evaluation of the value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or

2. such other amount as the Participating Dentist and a Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or
3. if an amount is not determined as described in either 1. or 2. above, the amount a Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

Alternate Benefit Provision (ABP) – a provision that allows benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

Authorization – the procedure for obtaining the Plan's prior approval for all services provided to Members under the contract other than your Dental Provider and Emergency Services.

Benefits (Covered Services) – those services which a Member is entitled to receive pursuant to the terms of this Agreement.

Calendar Year – a period beginning at 12:01 A.M. on January 1 and ending at 12:01 A.M. January 1 of the next year.

Close Relative – the spouse, Domestic Partner, child, brother, sister or parent of a Subscriber or Dependent.

Copayment – the amount that a Member is required to pay for certain Covered Services after meeting any applicable Deductible.

Cosmetic – any procedure, surgery, service, appliance, or supply that is not Medically Necessary but is solely designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

Covered Services (Benefits) – those services which a Member is entitled to receive pursuant to the terms of this Agreement.

Deductible – the Calendar Year amount you must pay for specific Covered Services that are a benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those services.

Dental Care Services – necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Center – a Dentist or a dental practice (with one or more Dentists) which has contracted with a Dental Plan Administrator to provide dental care Benefits to Members and to diagnose, provide, refer, supervise and coordinate the provision of all Benefits to Members in accordance with this Agreement.

Dental Plan Administrator (DPA) – a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

Dental Provider (Participating Dentist) – a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan Members in accordance with this Agreement.

Dental Service Plan (Plan) – the Plan issued by Blue Shield to the contract holder that establishes the Benefits that Members are entitled to receive from the Plan.

Dentist – a duly licensed Doctor of Dental Surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

Dependent –

an individual who meets one of the following eligibility requirements:

1. A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber.
2. A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Agreement.
3. A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

Domestic Partner – an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1) Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

2) The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; and

4) Both partners are capable of consenting to the domestic partnership; and

5) Both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Emergency Services – services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. subjecting the member to undue suffering.

Endodontics – Dental Care Services specifically related to necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization.

Experimental or Investigational in Nature – any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Implants – artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue, or the removal of Implants (surgically or otherwise).

Medical Necessity (Medically Necessary) – Benefits are provided only for services that are Medically Necessary.

1. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted national and California dental standards to treat illness, injury, or dental condition, and which, as determined by the Dental Plan Administrator, are:
   a. consistent with the Dental Plan Administrator's dental policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Dentist or other provider;
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient; and
   e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or dental condition.

Member – an individual who is enrolled and maintains coverage in the plan pursuant to this Agreement as either a Subscriber or a Dependent. Use of "you" in this document refers to the Member.

Non-Participating Dentist – a Dental Center, Plan Specialist, or other Dental Provider who has not signed a service contract with a contracted Dental Plan Administrator to provide dental services to Subscribers.

Open Enrollment Period – the yearly period during which an individual may enroll or change coverage. The Open Enrollment Period is established each year by California law.

Oral Surgery – Dental Care Services specifically related to the diagnosis and the surgical and adjunctive treatment of diseases, injuries and defects of the mouth, jaws and associated structures.

Orthodontics (Orthodontic) – Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth.

Out-of-Pocket Maximum – The highest Deductible, Copayment, and Coinsurance amount an individual or family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.

Palliative Treatment – therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

Participating Dentist – a Dental Center, Plan Specialist, or other Dental Provider who has an agreement with a contracted Dental Plan Administrator to provide Plan Benefits to Members.

Pediatric – Members age 0-18 (birth to 18 years of age). Pediatric Benefits are available through the end of the month in which the Member turns 19.

Pedodontics – Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

Periodontics – Dental Care Services specifically related to necessary procedures for providing treatment of disease of gums and bones supporting the teeth, not requiring hospitalization.

Plan – the Blue Shield of California Family Dental HMO Plan.

Plan Specialist – a Dentist who is licensed or authorized by the State of California to provide specialized Dental Care Services as recognized by the appropriate specialty board of the American Dental Association, and, who has an agreement with a contracted Dental Plan Administrator to provide Covered Services to Members on referral by Dental Provider.

Premiums – the monthly pre-payment that is made to the Plan on behalf of each Member.

Prosthesis – an artificial part, appliance or device used to replace a missing part of the body.

Prosthodontics – Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Qualified Dental Plan (QDP) - a dental plan that has been certified for sale through Covered California.

Qualified Individual - An enrollee deemed eligible for coverage by Covered California.

Resident of California – an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Service Area – that geographic area served by the Plan.

Subscriber – an individual who satisfies the eligibility requirements of this Agreement, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Agreement.

Treatment in Progress – partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken. Ongoing Orthodontic cases are not considered Treatment in Progress under this definition.

Triggering Event - A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Office, to take effect on the Subscriber's effective date.

Patrice Bergman
Vice President and General Manager
Individual and Family Plans
Blue Shield of California

Dental Customer Service Telephone Numbers:

Blue Shield of California
Dental Plan Administrator
1-888-271-4880

Blue Shield of California
1-877-885-0254

Dental Customer Service Correspondence Address:

Blue Shield of California
Dental Plan Administrator
Dental Customer Service
425 Market Street, 15th Floor
San Francisco, CA 94105

Claims for all Covered Services should be sent to:

Blue Shield of California
P. O. Box 30567
Salt Lake City, UT 84130-0567

Dental Schedule and Limitations Table

The below schedule outlines the dental Benefits covered by this Plan along with limitations related to the listed dental procedure codes:

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
Diagnostic Procedures (D0100-D0999)					
D0120	Periodic oral evaluation - established patient	once every 6 months, per provider or after 6 months have elapsed following comprehensive oral evaluation (D0150), same provider.	No Charge	once every 6 months or after 6 months have elapsed following comprehensive oral evaluation (D0150).	No Charge
D0140	Limited oral evaluation – problem focused	once per Member per provider.	No Charge	once within a 1-month period for the same dental problem.	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		No Charge	not a Benefit.	Not Covered
D0150	Comprehensive oral evaluation – new or established patient	once per Member per provider for the initial evaluation.	No Charge	once every 3 years and not within the same 6-month period as D0120 & D0145 or when new office is assigned, included in the two total exams per year.	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	once per Member per provider.	No Charge	once within a 1-month period for the same dental problem.	No Charge
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	a Benefit for the ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.	No Charge	once within a 1-month period for the same dental problem.	No Charge
D0171	Re-evaluation – post-operative office visit		No Charge	once within a 1-month period for the same dental problem.	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient		No Charge	once every 24-months.	No Charge
D0190	Screening of a patient	not a Benefit.	Not Covered		No Charge
D0191	Assessment of a patient	not a Benefit.	Not Covered		No Charge
D0210	Intraoral - comprehensive series of radiographic images	once per provider every 36 months.	No Charge	once every 3 years.	No Charge

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D0220	Intraoral - periapical first radiographic image	up 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). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.	No Charge	one per day.	No Charge
D0230	Intraoral - periapical each additional radiographic image	up 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). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.	No Charge	up to 3 per day.	No Charge
D0240	Intraoral - occlusal radiographic image	up to a maximum of two in a 6 month period per provider.	No Charge	up to 2 per visit.	No Charge
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.	No Charge	one per year.	No Charge
D0251	Extra-oral posterior dental radiographic image	up to a maximum of 4 on the same date of service.	No Charge	not a Benefit.	Not Covered
D0270	Bitewing - single radiographic image	once per date of service. Not a Benefit for a totally edentulous area.	No Charge	two per 6-month period. Total number of bitewings should not be more than four (4) in a 1-year period.	No Charge
D0272	Bitewings - 2 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral complete series of radiographic images (D0210), same provider; and b. for a totally edentulous area.	No Charge	one set of two x-rays per 6-month period. Total number of bitewings should not be more than four (4) in a 1-year period.	No Charge

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D0273	Bitewings - 3 radiographic images		No Charge	one per year. Total number of bitewings should not be more than four (4) in a 1-year period.	No Charge
D0274	Bitewings - 4 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral-complete series of radiographic images (D0210), same provider; b. for Members under the age of 10; and c. for a totally edentulous area.	No Charge	one per year. Total number of bitewings should not be more than four (4) in a 1-year period.	No Charge
D0277	Vertical bitewings - 7 to 8 radiographic images		No Charge	once per 12-month period.	No Charge
D0310	Sialography		No Charge	not a Benefit.	Not Covered
D0320	Temporomandibular joint arthrogram, including injection	limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.	No Charge	not a Benefit.	Not Covered
D0322	Tomographic survey	up to twice in a 12 month period per provider.	No Charge	not a Benefit.	Not Covered
D0330	Panoramic radiographic image	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).	No Charge	once in a 36 month period as a substitute for D0210 or D0277 or one per day for diagnosis of third molars, cysts, or neoplasms. One D0210, D0277or D0330 per 36-month period.	No Charge
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12 month period per provider.	No Charge	not a Benefit.	Not Covered
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	up to a maximum of 4 per date of service.	No Charge	not a Benefit.	Not Covered
D0396	3D printing of a 3D dental surface scan		No Charge		No Charge
D0419	Assessment of salivary flow by measurement	not a Benefit.	Not Covered	not a Benefit.	Not Covered
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 a Benefit.	Not Covered	once every 12-month period for Adults 21 years old and greater.	No Charge
D0460	Pulp vitality tests		No Charge	not billable as a separate procedure & included as part of the diagnosis.	No Charge

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D0470	Diagnostic casts	once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment); for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly); and when provided by a certified orthodontist.	No Charge		No Charge
D0502	Other oral pathology procedures, by report	must be provided by a certified oral pathologist.	No Charge	not a Benefit.	Not Covered
D0601	Caries risk assessment and documentation, with a finding of low risk		No Charge	once per year when done in conjunction with D0120, D0150.	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk		No Charge	once per year when done in conjunction with D0120, D0150.	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk		No Charge	once per year when done in conjunction with D0120, D0150.	No Charge
D0701	Panoramic radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0702	2-D cephalometric radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only		No Charge	not a Benefit.	Not Covered
D0705	Extra-oral posterior dental radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0706	Intraoral – occlusal radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0707	Intraoral – periapical radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0708	Intraoral – bitewing radiographic image – image capture only		No Charge	not a Benefit.	Not Covered
D0709	Intraoral – comprehensive series of radiographic images – image capture only		No Charge	not a Benefit.	Not Covered
D0801	3D dental surface scan - direct		No Charge	not a Benefit.	Not Covered
D0802	3D dental surface scan - indirect		No Charge	not a Benefit.	Not Covered
D0803	3D facial surface scan - direct		No Charge	not a Benefit.	Not Covered
D0804	3D facial surface scan - indirect		No Charge	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D0999	Unspecified diagnostic procedure, by report		No Charge	includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	No Charge
Preventive Procedures (D1000-D1999)					
D1110	Prophylaxis - Adult		No Charge	once in a 6 month period.	No Charge
D1120	Prophylaxis – child	once in a 6 month period.	No Charge	not a Benefit.	Not Covered
D1206	Topical application of fluoride varnish	once in a 6 month period.	No Charge	3 in a 12-month period for a Member with moderate to high risk caries.	No Charge
D1208	Topical application of fluoride – excluding varnish	once in a 6 month period.	No Charge	not a Benefit.	Not Covered
D1310	Nutritional counseling for control of dental disease		No Charge	integral to D0120, D0150, D0145; not a separate billable item	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, and systemic health effects associated with high-risk substance use		No Charge		No Charge
D1330	Oral hygiene instructions		No Charge	integral to D0120, D0150, D0145, D0140, D1110, D1204, D1201; not a separate billable item.	No Charge
D1351	Sealant – per tooth	limited to the 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; and once per tooth every 36 months per provider regardless of surfaces sealed.	No Charge	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	limited to the for first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed.	No Charge	not a Benefit.	Not Covered
D1353	Sealant repair – per tooth		No Charge	not a Benefit.	Not Covered
D1354	Interim caries arresting medicament application – per tooth		No Charge	2 applications per calendar year per tooth. Applicable to all deciduous or permanent teeth. Conservative treatment of active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	No Charge
D1355	Caries preventive medicament application – per tooth		No Charge	2 applications per calendar year per tooth. Applicable to all deciduous or permanent teeth. Medication contains no fluoride. Conservative treatment of active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	No Charge
D1510	Space maintainer-fixed – unilateral – per quadrant	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.	No Charge	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D1516	Space maintainer – fixed – bilateral, maxillary	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 and for Members under the age of 18 Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge	not a Benefit.	Not Covered
D1517	Space maintainer – fixed – bilateral, mandibular	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 and for Members under the age of 18 Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge	not a Benefit.	Not Covered
D1520	Space maintainer-removable – unilateral – per quadrant	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D1526	Space maintainer – removable – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge	not a Benefit.	Not Covered
D1527	Space maintainer – removable – bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge	not a Benefit.	Not Covered
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge	not a Benefit.	Not Covered
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge	not a Benefit.	Not Covered
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge	not a Benefit.	Not Covered
D1556	Removal of fixed unilateral space maintainer - per quadrant	not a Benefit to the original provider who placed the space maintainer.	No Charge	not a Benefit.	Not Covered
D1557	Removal of fixed bilateral space maintainer - maxillary	not a Benefit to the original provider who placed the space maintainer.	No Charge	not a Benefit.	Not Covered
D1558	Removal of fixed bilateral space maintainer - mandibular	not a Benefit to the original provider who placed the space maintainer.	No Charge	not a Benefit.	Not Covered
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant		No Charge	not a Benefit.	Not Covered
Restorative Procedures (D2000-D2999)					

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2140	Amalgam – 1 surface, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$25	once per 12-month period per tooth. .	$25
D2150	Amalgam – 2 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30	once per 12-month period per tooth.	$30
D2160	Amalgam – 3 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$40	once per 12-month period per tooth.	$40
D2161	Amalgam – 4 or more surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$45	once per 12-month period per tooth.	$45
D2330	Resin-based composite – 1 surface, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30	once per 12-month period per tooth.	$30
D2331	Resin-based composite – 2 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$45	once per 12-month period per tooth.	$45
D2332	Resin-based composite – 3 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$55	once per 12-month period per tooth.	$55
D2335	Resin-based composite – 4 or more surfaces (anterior)	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$60	once per 12-month period per tooth.	$60
D2390	Resin-based composite crown, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$50	once per 5 years.	$50
D2391	Resin-based composite – 1 surface, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30	once per 12-month period per tooth.	$30
D2392	Resin-based composite – 2 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$40	once per 12-month period per tooth.	$40
D2393	Resin-based composite – 3 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$50	once per 12-month period per tooth.	$50
D2394	Resin-based composite – 4 or more surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$70	once per 12-month period per tooth.	$70

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2542	Onlay - metallic – 2 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$185
D2543	Onlay - metallic – 3 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$200
D2544	Onlay - metallic – 4 or more surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$215
D2642	Onlay - porcelain/ceramic – 2 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement). Cannot submit with D2610-D2630.	$250
D2643	Onlay - porcelain/ceramic – 3 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement). Cannot submit with D2610-D2630.	$275
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement). Cannot submit with D2610-D2630.	$300
D2662	Onlay - resin-based composite – 2 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$160
D2663	Onlay - resin-based composite – 3 surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$180
D2664	Onlay - resin-based composite – 4 or more surfaces	not a Benefit.	Not Covered	one per five years per surface combination. Must include one or more of the following surfaces: B, L (cusp replacement).	$200

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2710	Crown – resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. 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; and b. for use as a temporary crown.	$140	one crown per tooth per five years.	$140
D2712	Crown - 3/4 resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. 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; and b. for use as a temporary crown.	$190	one crown per tooth per five years.	$200
D2720	Crown – resin with high noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2721	Crown – resin with predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: 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.	$300	one crown per tooth per five years.	$300
D2722	Crown – resin with noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2740	Crown – porcelain/ceramic	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: 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.	$300	one crown per tooth per five years.	$300
D2750	Crown – porcelain fused to high noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2751	Crown – porcelain fused to predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: 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.	$300	one crown per tooth per five years.	$300
D2752	Crown – porcelain fused to noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2753	Crown – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2780	Crown – 3/4 cast high noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2781	Crown – 3/4 cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: 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.	$300	one crown per tooth per five years.	$300
D2782	Crown – 3/4 cast noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2783	Crown – 3/4 porcelain/ceramic	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: 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.	$310	one crown per tooth per five years.	$310
D2790	Crown – full cast high noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2791	Crown – full cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: 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.	$300	one crown per tooth per five years.	$300
D2792	Crown – full cast noble metal	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2794	Crown – titanium and titanium alloys	not a Benefit.	Not Covered	one crown per tooth per five years.	$300
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider.	$25	once per 6-month period.	$25
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		$25	once per 5 years per tooth.	$25
D2920	Re-cement or re-bond crown	the original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a Benefit within 12 months of a previous re-cementation by the same provider.	$25	once per 6-month period.	$15
D2921	Reattachment of tooth fragment, incisal edge or cusp		$45	anterior upper tooth only; once per 24-month period.	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	once in a 12 month period.	$120	not a Benefit.	Not Covered
D2929	Prefabricated porcelain/ceramic crown - primary tooth	once in a 12 month period.	$95	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2930	Prefabricated stainless steel crown – primary tooth	once in a 12 month period.	$65	not a Benefit.	Not Covered
D2931	Prefabricated stainless steel crown – permanent tooth	once in a 36 month period. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$75	once per 3 years per tooth. Tooth numbers 1-5, 12-20, and 28-32.	$75
D2932	Prefabricated resin crown	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$75	not a Benefit.	Not Covered
D2933	Prefabricated stainless steel crown with resin window	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$80	not a Benefit.	Not Covered
D2940	Protective restoration	once per tooth in a 6 month period, per provider. Not a Benefit: a. when performed on the same date of service with a permanent restoration or crown, for same tooth; and b. on root canal treated teeth.	$25	one per 6-month period per tooth.	$20
D2941	Interim therapeutic restoration – primary dentition		$30	not a Benefit.	Not Covered
D2949	Restorative foundation for an indirect restoration		$45	not a Benefit.	Not Covered
D2950	Core buildup, including any pins when required		$20	once per five years per tooth for tooth numbers 1-32. Not a benefit to restore undercuts in the preparation or “cavities” that develop as the result of removing pathology (decay) from the prepared tooth.	$20

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2951	Pin retention – per tooth, in addition to restoration	for permanent teeth only; when performed on the same date of service with an amalgam or composite; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves 3 or more connected surfaces and at least 1 cusp; or, for an anterior restoration when extensive coronal destruction involves the incisal angle.	$25	once per restoration, regardless of number of pins used for tooth numbers 1-32.	$20
D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.	$100	once per five years per tooth for tooth numbers 1-32.	$60
D2953	Each additional indirectly fabricated post – same tooth		$30	once per five years per tooth for tooth numbers 1-32.	$30
D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.	$90	once per five years per tooth for tooth numbers 1-32.	$60
D2955	Post removal		$60	not a Benefit.	Not Covered
D2957	Each additional prefabricated post - same tooth		$35	once per five years per tooth for tooth numbers 1-32.	$35
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework		$35	not a Benefit.	Not Covered
D2976	Band stabilization – per tooth		$40		$40
D2980	Crown repair, necessitated by restorative material failure	limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.	$50	once per 6-month period per tooth.	$50
D2989	Excavation of a tooth resulting in the determination of non-restorability		$50		$50
D2991	Application of hydroxyapatite regeneration medicament – per tooth		No Charge		No Charge

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D2999	Unspecified restorative procedure, by report		$40	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$40
Endodontic Procedures (D3000-D3999)					
D3110	Pulp cap – direct (excluding final restoration)		$20	once per tooth per lifetime.	$20
D3120	Pulp cap – indirect (excluding final restoration)		$25	not payable as a separate benefit. considered part of final restoration.	$25
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. for a primary tooth with a necrotic pulp or a periapical lesion; c. for a primary tooth that is non-restorable; and d. for a permanent tooth.	$40	once per tooth per lifetime.	$35
D3221	Pulpal debridement, primary and permanent teeth	once per permanent tooth; over-retained primary teeth with no permanent successor. Not a Benefit on the same date of service with any additional services, same tooth.	$40	once per tooth per lifetime.	$50

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	once per permanent tooth. Not a Benefit: a. for primary teeth; b. 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; and c. on the same date of service as any other endodontic procedures for the same tooth.	$60	not a Benefit.	Not Covered
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.	$55	not a Benefit.	Not Covered
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.	$55	not a Benefit.	Not Covered
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	$195	once per tooth per lifetime for tooth numbers 6-11, 22-27.	$200
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	$235	once per tooth per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, and 29.	$235

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3330	Endodontic therapy, molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment. 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.	$300	once per tooth per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31.	$300
D3331	Treatment of root canal obstruction; non-surgical access		$50	not a benefit for teeth 1, 16, 17, 32.	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	not a Benefit.	Not Covered	once per tooth per lifetime for teeth 1-32 only.	$85
D3333	Internal root repair of perforation defects		$80	not a Benefit.	Not Covered
D3346	Retreatment of previous root canal therapy – anterior	once per tooth after more than 12 months has elapsed from initial treatment.	$240	once per tooth per lifetime for tooth numbers 6-11, 22-27.	$245
D3347	Retreatment of previous root canal therapy – premolar	once per tooth after more than 12 months has elapsed from initial treatment.	$295	once per tooth per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, and 29.	$295
D3348	Retreatment of previous root canal therapy – molar	once per tooth after more than 12 months has elapsed from initial treatment. 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.	$350	once per tooth per lifetime for tooth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32.	$350
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	once per permanent tooth. Not a Benefit: a. for primary teeth; b. 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; and c. on the same date of service as any other endodontic procedures for the same tooth.	$85	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3352	Apexification/recalcification - interim medication replacement	once per permanent tooth and only following apexification/ recalcification initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a Benefit: a. for primary teeth; b. 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; and c. on the same date of service as any other endodontic procedures for the same tooth.	$45	not a Benefit.	Not Covered
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	not a Benefit.	Not Covered	not a Benefit.	Not Covered
D3410	Apicoectomy – anterior	for permanent anterior teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.	$240	once per root per lifetime for tooth numbers 6-11, 22-27. not a Benefit during the first 6-8 weeks after RCT (D3310).	$240

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3421	Apicoectomy – premolar (first root)	for permanent bicuspid teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented, after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. 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.	$250	once per root per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, and 29. Not a Benefit during the first 6-8 weeks after RCT (D3320) to perform this procedure.	$250
D3425	Apicoectomy – molar (first root)	for permanent 1st and 2nd molar teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. 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.	$275	once per root per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. Not a Benefit during the first 6-8 weeks after RCT (D3330) to perform this procedure. Not a benefit to retain the tooth as an abutment for a future dental prosthesis or because the tooth is simply in occlusion with its opposing tooth.	$275

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3426	Apicoectomy – (each additional root)	for permanent teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.	$110	once per root per lifetime for tooth numbers 2-5, 12-15, 18-21, 28- 31. Not a Benefit during the first 6-8 weeks after RCT (D3330) to perform this procedure.	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site		$350	not a Benefit.	Not Covered
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site		$350	not a Benefit.	Not Covered
D3430	Retrograde filling – per root		$90	once per root per lifetime for tooth numbers 2-15, 18-31. Not a Benefit for 6-8 weeks after RCT (D3310, D3320, D3330) to perform this procedure. Not a benefit to retain the tooth as an abutment for a future dental prosthesis or because the tooth is simply in occlusion with its opposing tooth.	$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 a Benefit.	Not Covered		$145
D3450	Root amputation - per root	not a Benefit.	Not Covered	once per root per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31 only.	$110
D3471	Surgical repair of root resorption – anterior		$160	once per root per lifetime for only tooth numbers 6-11, 22-27.	$160
D3472	Surgical repair of root resorption – premolar		$160	once per root per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, 29.	$160
D3473	Surgical repair of root resorption – molar		$160	once per root per lifetime for only tooth numbers 3, 4, 14, 15, 18, 19, 30, 31.	$160
D3910	Surgical procedure for isolation of tooth with rubber dam		$30	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D3920	Hemisection (including any root removal), not including root canal therapy	not a Benefit.	Not Covered	once per tooth, per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31 only.	$120
D3950	Canal preparation and fitting of preformed dowel or post	not a Benefit.	Not Covered		$60
D3999	Unspecified endodontic procedure, by report		$100	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$100
Periodontics Procedures (D4000-D4999)					
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$150	one surgery per site per 36 months. A Benefit for teeth (on a site) with 6 mm or greater pockets not caused by pseudo-pocketing from gingival inflammation. Not a Benefit for cosmetic purposes.	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$50	one surgery per tooth per 36 months. a Benefit for teeth (on a site) with 6 mm or greater pockets not caused by pseudo-pocketing from gingival inflammation. Not a Benefit for cosmetic purposes.	$50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Not Covered	once per quadrant per 24-month period.	$135
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Not Covered	once per quadrant per 24-month period.	$70

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.	$165	once per tooth per 5 years.	$200
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$265	once per quadrant per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). a Benefit if the prognosis of the teeth being treated is good (longevity of 5 years).	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$140	once per quadrant per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). a Benefit if the prognosis of the teeth being treated is good (longevity of 5 years).	$140
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	not a Benefit.	Not Covered	once per site per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). a Benefit if the prognosis of the teeth being treated is good (longevity of 5 years).	$105
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	not a Benefit.	Not Covered	once per site per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). a Benefit if the prognosis of the teeth being treated is good (longevity of 5 years).	$75
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	for Members age 13 or older.	$80	not a Benefit.	Not Covered
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	not a Benefit.	Not Covered	once per site per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). Not a Benefit for cosmetic purposes.	$145

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	not a Benefit.	Not Covered	once per site per 36-month period. Not a Benefit for 6-8 weeks after scaling and root planning (D4341). Not a Benefit for cosmetic purposes.	$175
D4270	Pedicle soft tissue graft procedure	not a Benefit.	Not Covered	one surgery per site per 36-month period. Not a Benefit for cosmetic purposes. Not a Benefit for natural gingival recession that occurs with the natural aging process or overzealous brushing (tooth brush abrasion).	$155
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	not a Benefit.	Not Covered	one surgery per site per 36-month period. Not a Benefit for cosmetic purposes. Not a Benefit for natural gingival recession that occurs with the natural aging process or overzealous brushing (tooth brush abrasion).	$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 a Benefit.	Not Covered	not a Benefit.	Not Covered
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 a Benefit.	Not Covered	one surgery per site per 36-month period.	$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 a Benefit.	Not Covered	not a Benefit.	Not Covered
D4286	Removal of non-resorbable barrier	not a Benefit.	Not Covered		$175
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.	$55	once per quadrant per 24-month period. Two quadrants per visit maximum.	$55

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.	$30	once per quadrant per 24-month period.	$25
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation NOTE: This code is categorized as Periodontal Maintenance (Basic Services). For cost share information, please refer to the Basic Services category rather than Major Services on the Summary of Benefits.		$40	once per 12-month period.	$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	for Members age 13 or older.	$40	once every 3 years.	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	for Members age 13 or older.	$10		$10
D4910	Periodontal maintenance NOTE: This code is categorized as Periodontal Maintenance (Basic Services). For cost share information, please refer to the Basic Services category rather than Major Services on the Summary of Benefits.	once in a calendar quarter and only in the 24 month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning.	$30	once every 6-month period following active periodontal therapy (exclusive of D4355). Not a Benefit within the first 4 weeks following periodontal treatment.	$30
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D4999	Unspecified periodontal procedure, by report	for Members age 13 or older.	$350	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$350
Prosthodontics, removable Procedures (D5000-D5899)					
D5110	Complete denture – maxillary	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.	$300	once per 5 years.	$400
D5120	Complete denture – mandibular	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5751) or chairside reline (D5731) is a Benefit 12 months after the date of service for this procedure.	$300	once per 5 years.	$400
D5130	Immediate denture – maxillary	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 6 months after the date of service for this procedure.	$300	once per 5 years.	$400
D5140	Immediate denture – mandibular	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture.	$300	once per 5 years.	$400

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)		$300	once per 5 years.	$325
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)		$300	once per 5 years.	$325
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$335	once per 5 years.	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$335	once per 5 years.	$375
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275	once per five years.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275	once per five years.	$300
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330	once per five years.	$370

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330	once per five years.	$370
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	not a Benefit.	Not Covered	once per 5 years. A Benefit for Members age 21 years and older.	$375
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	not a Benefit.	Not Covered	once per 5 years. A Benefit for Members age 21 years and older.	$375
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	not a Benefit.	Not Covered	not a Benefit.	Not Covered
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	not a Benefit.	Not Covered	not a Benefit.	Not Covered
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	not a Benefit.	Not Covered	once per five years.	$250
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	not a Benefit.	Not Covered	once per five years.	$250
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	not a Benefit.	Not Covered	once per five years.	$250
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	not a Benefit.	Not Covered	once per five years.	$250

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5410	Adjust complete denture – maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a complete denture-maxillary (D5110), immediate denture- maxillary (D5130) or overdenture-complete (D5860); b. same date of service or within 6 months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850); and c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).	$20	once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5110, D5130) or relined (D5730, D5750).	$20

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5411	Adjust complete denture – mandibular	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a complete denture-mandibular (D5120), immediate denture-mandibular (D5140) or overdenture-complete (D5860); b. same date of service or within 6 months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851); and c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).	$20	once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5120, D5140) or relined (D5731, D5751).	$20

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5421	Adjust partial denture – maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. Same date of service or within 6 months of the date of service of a maxillary partial resin base (5211) or maxillary partial denture cast metal framework with resin denture bases (D5213); b. same date of service or within 6 months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850); and c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & 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).	$20	once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5211, D5213) or relined (D5740, D5760).	$20

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5422	Adjust partial denture – mandibular	once per date of service per provider and no more than twice in a 12month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214); b. same date of service or within 6 months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851); and c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & 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).	$20	once per 6-month period per prosthesis.	$20
D5511	Repair broken complete denture base, mandibular	once per date of service per provider and no more than 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).	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5110, D5120, D5130, and D5140	$30

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5512	Repair broken complete denture base, maxillary	once per date of service per provider and no more than 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).	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5110, D5120, D5130, and D5140	$30
D5520	Replace missing or broken teeth – complete denture (each tooth)	up to a maximum of 4, per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5110, D5120, D5130, and D5140	$30
D5611	Repair resin denture base, mandibular	once per date of service per provider; no more than twice in a 12 month period per provider; and 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).	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$30
D5612	Repair resin denture base, maxillary	once per date of service per provider; no more than twice in a 12 month period per provider; and 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).	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$30

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5621	Repair cast framework, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider.	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5213, D5214).	$35
D5622	Repair cast framework, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider.	$40	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5213, D5214).	$35
D5630	Repair or replace broken clasp – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$50	once per 6-month period for the same problem. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$30
D5640	Replace broken teeth – per tooth	up to a maximum of 4, per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only.	$35	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$30
D5650	Add tooth to existing partial denture	once per tooth and up to a maximum of 3, per date of service per provider. Not a Benefit for adding 3rd molars.	$35	once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$35
D5660	Add clasp to existing partial denture – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$60	once per clasp per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5211, D5212, D5213, and D5214).	$45
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	not a Benefit.	Not Covered	once per 5 years. A Benefit for Members age 21 years and older.	$195

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	not a Benefit.	Not Covered	once per 5 years. A Benefit for Members age 21 years and older.	$195
D5710	Rebase complete maxillary denture	not a Benefit.	Not Covered	once per 12-month period per procedure. A Benefit for Members age 21 years and older. Not a Benefit for the first 12 months after new denture delivery.	$155
D5711	Rebase complete mandibular denture	not a Benefit.	Not Covered	once per 12-month period per procedure. A Benefit for Members age 21 years and older. Not a Benefit for the first 12 months after new denture delivery.	$155
D5720	Rebase maxillary partial denture	not a Benefit.	Not Covered	once per 12-month period per procedure. Not a Benefit for the first 12 months after new denture delivery.	$150
D5721	Rebase mandibular partial denture	not a Benefit.	Not Covered	once per 12-month period per procedure. Not a Benefit for the first 12 months after new denture delivery.	$150
D5730	Reline complete maxillary denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).	$60	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5110, D5130).	$80

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5731	Reline complete mandibular denture (chairside)	once in a 12 month period; 6 months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).	$60	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5120, D5140).	$80
D5740	Reline maxillary partial denture (chairside)	once in a 12 month period; 6 months after the date of service for maxillary partial denture-resin base (D5211) or 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- resin base (D5211) or 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 (laboratory) (D5760).	$60	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5211, D5213).	$75
D5741	Reline mandibular partial denture (chairside)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- resin base (D5212) or 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 resin base (D5212) or 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 (laboratory) (D5761).	$60	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5212, D5214).	$75

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5750	Reline complete maxillary denture (laboratory)	once in a 12 month period; 6 months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).	$90	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5110, D5130).	$120
D5751	Reline complete mandibular denture (laboratory)	once in a 12 month period; 6 months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture – mandibular (D5120) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).	$90	once per 12-month period per procedure. Not a Benefit for six months after denture placed (5120, 5140).	$120

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5760	Reline maxillary partial denture (laboratory)	once in a 12 month period and 6 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: a. within 12 months of a reline maxillary partial denture (chairside) (D5740); and b. for maxillary partial denture resin base (D5211).	$80	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5211, D5213).	$110
D5761	Reline mandibular partial denture (laboratory)	once in a 12 month period; 6 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: a. within 12 months of a reline mandibular partial denture (chairside) (D5741); and b. for a mandibular partial denture resin base (D5212).	$80	once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5212, D5214).	$110
D5850	Tissue conditioning, maxillary	twice per prosthesis in a 36 month period. Not a Benefit: a. 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); and b. same date of service as a prosthesis that did not require extractions.	$30	once per 6-month period per prosthesis. A Benefit for Members age 21 years and older. Not a Benefit within 6 months after new full or partial denture delivery or relined/rebased prosthesis.	$35

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5851	Tissue conditioning, mandibular	twice per prosthesis in a 36 month period. Not a Benefit: a. 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); and b. same date of service as a prosthesis that did not require extractions.	$30	once per 6-month period per prosthesis. A Benefit for Members age 21 years and older. Not a Benefit within 6 months after new full or partial denture delivery or relined/rebased prosthesis.	$35
D5862	Precision attachment, by report		$90	not a Benefit.	Not Covered
D5863	Overdenture – complete maxillary	once in a 5 year period.	$300	not a Benefit.	Not Covered
D5864	Overdenture – partial maxillary	once in a 5 year period.	$300	not a Benefit.	Not Covered
D5865	Overdenture – complete mandibular	once in a 5 year period.	$300	not a Benefit.	Not Covered
D5866	Overdenture – partial mandibular	once in a 5 year period.	$300	not a Benefit.	Not Covered
D5876	Add metal substructure to acrylic full denture (per arch)	not a Benefit.	Not covered	not a Benefit.	Not Covered
D5899	Unspecified removable prosthodontic procedure, by report		$350	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the Rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$400
Maxillofacial Prosthetics Procedures (D5900-D5999)					
D5911	Facial moulage (sectional)		$285	not a Benefit.	Not Covered
D5912	Facial moulage (complete)		$350	not a Benefit.	Not Covered
D5913	Nasal prosthesis		$350	not a Benefit.	Not Covered
D5914	Auricular prosthesis		$350	not a Benefit.	Not Covered
D5915	Orbital prosthesis		$350	not a Benefit.	Not Covered
D5916	Ocular prosthesis	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	$350	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5919	Facial prosthesis		$350	not a Benefit.	Not Covered
D5922	Nasal septal prosthesis		$350	not a Benefit.	Not Covered
D5923	Ocular prosthesis, interim	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	$350	not a Benefit.	Not Covered
D5924	Cranial prosthesis		$350	not a Benefit.	Not Covered
D5925	Facial augmentation implant prosthesis		$200	not a Benefit.	Not Covered
D5926	Nasal prosthesis, replacement		$200	not a Benefit.	Not Covered
D5927	Auricular prosthesis, replacement		$200	not a Benefit.	Not Covered
D5928	Orbital prosthesis, replacement		$200	not a Benefit.	Not Covered
D5929	Facial prosthesis, replacement		$200	not a Benefit.	Not Covered
D5931	Obturator prosthesis, surgical	not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).	$350	not a Benefit.	Not Covered
D5932	Obturator prosthesis, definitive	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).	$350	not a Benefit.	Not Covered
D5933	Obturator prosthesis, modification	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).	$150	not a Benefit.	Not Covered
D5934	Mandibular resection prosthesis with guide flange		$350	not a Benefit.	Not Covered
D5935	Mandibular resection prosthesis without guide flange		$350	not a Benefit.	Not Covered
D5936	Obturator prosthesis, interim	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).	$350	not a Benefit.	Not Covered
D5937	Trismus appliance (not for TMD treatment)		$85	not a Benefit.	Not Covered
D5951	Feeding aid	for Members under the age of 18 only.	$135	not a Benefit.	Not Covered
D5952	Speech aid prosthesis, pediatric	for Members under the age of 18 only.	$350	not a Benefit.	Not Covered
D5953	Speech aid prosthesis, Adult	for Members under the age of 18 only.	$350	not a Benefit.	Not Covered
D5954	Palatal augmentation prosthesis		$135	not a Benefit.	Not Covered
D5955	Palatal lift prosthesis, definitive	not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).	$350	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D5958	Palatal lift prosthesis, interim	not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).	$350	not a Benefit.	Not Covered
D5959	Palatal lift prosthesis, modification	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).	$145	not a Benefit.	Not Covered
D5960	Speech aid prosthesis, modification	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).	$145	not a Benefit.	Not Covered
D5982	Surgical stent		$70	not a Benefit.	Not Covered
D5983	Radiation carrier		$55	not a Benefit.	Not Covered
D5984	Radiation shield		$85	not a Benefit.	Not Covered
D5985	Radiation cone locator		$135	not a Benefit.	Not Covered
D5986	Fluoride gel carrier	a Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.	$35	not a Benefit.	Not Covered
D5987	Commissure splint		$85	not a Benefit.	Not Covered
D5988	Surgical splint		$95	not a Benefit.	Not Covered
D5991	Vesiculobullous disease medicament carrier		$70	not a Benefit.	Not Covered
D5999	Unspecified maxillofacial prosthesis, by report		$350	not a Benefit.	Not Covered
Implant Service Procedures (D6000-D6199)					
D6010	Surgical placement of implant body: endosteal implant		$350	not a Benefit.	Not Covered
D6011	Surgical access to an implant body (second stage implant surgery)		$350	not a Benefit.	Not Covered
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant		$350	not a Benefit.	Not Covered
D6013	Surgical placement of mini implant		$350	not a Benefit.	Not Covered
D6040	Surgical placement: eposteal implant		$350	not a Benefit.	Not Covered
D6050	Surgical placement: transosteal implant		$350	not a Benefit.	Not Covered
D6055	Connecting bar - implant supported or abutment supported		$350	not a Benefit.	Not Covered
D6056	Prefabricated abutment - includes modification and placement		$135	not a Benefit.	Not Covered
D6057	Custom fabricated abutment - includes placement		$180	not a Benefit.	Not Covered
D6058	Abutment supported porcelain/ceramic crown		$320	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6059	Abutment supported porcelain fused to metal crown (high noble metal)		$315	not a Benefit.	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)		$295	not a Benefit.	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)		$300	not a Benefit.	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)		$315	not a Benefit.	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)		$300	not a Benefit.	Not Covered
D6064	Abutment supported cast metal crown (noble metal)		$315	not a Benefit.	Not Covered
D6065	Implant supported porcelain/ceramic crown		$340	not a Benefit.	Not Covered
D6066	Implant supported crown – fused to high noble alloys		$335	not a Benefit.	Not Covered
D6067	Implant supported crown – high noble alloys		$340	not a Benefit.	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD		$320	not a Benefit.	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		$315	not a Benefit.	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		$290	not a Benefit.	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)		$300	not a Benefit.	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)		$315	not a Benefit.	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)		$290	not a Benefit.	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)		$320	not a Benefit.	Not Covered
D6075	Implant supported retainer for ceramic FPD		$335	not a Benefit.	Not Covered
D6076	Implant supported retainer FPD – porcelain fused to high noble alloys		$330	not a Benefit.	Not Covered
D6077	Implant supported retainer for metal FPD - high noble alloys		$350	not a Benefit.	Not Covered
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments		$30	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
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 a Benefit.	Not Covered
D6082	Implant supported crown - porcelain fused to predominantly base alloys		$335	not a Benefit.	Not Covered
D6083	Implant supported crown - porcelain fused to noble alloys		$335	not a Benefit.	Not Covered
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$335	not a Benefit.	Not Covered
D6085	Interim implant crown		$300	not a Benefit.	Not Covered
D6086	Implant supported crown - predominantly base alloys		$340	not a Benefit.	Not Covered
D6087	Implant supported crown - noble alloys		$340	not a Benefit.	Not Covered
D6088	Implant supported crown - titanium and titanium alloys		$340	not a Benefit.	Not Covered
D6089	Accessing and retorquing loose implant screw – per screw		$60	not a Benefit	Not Covered
D6090	Repair implant supported prosthesis, by report		$65	not a Benefit.	Not Covered
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment		$40	not a Benefit.	Not Covered
D6092	Re-cement or re-bond implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.	$25	not a Benefit.	Not Covered
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	not a Benefit within 12 months of a previous recementation by the same provider.	$35	not a Benefit.	Not Covered
D6094	Abutment supported crown – titanium and titanium alloys		$295	not a Benefit.	Not Covered
D6095	Repair implant abutment, by report		$65	not a Benefit.	Not Covered
D6096	Remove broken implant retaining screw		$60	not a Benefit.	Not Covered
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys		$315	not a Benefit.	Not Covered
D6098	Implant supported retainer - porcelain fused to predominantly base alloys		$330	not a Benefit.	Not Covered
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys		$330	not a Benefit.	Not Covered
D6100	Surgical removal of implant body		$110	not a Benefit.	Not Covered
D6105	Removal of implant body not requiring bone removal or flap elevation		$110	not a Benefit.	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary		$350	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular		$350	not a Benefit.	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary		$350	not a Benefit.	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular		$350	not a Benefit.	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary		$350	not a Benefit.	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular		$350	not a Benefit.	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary		$350	not a Benefit.	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular		$350	not a Benefit.	Not Covered
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular		$350	not a Benefit.	Not Covered
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary		$350	not a Benefit.	Not Covered
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$330	not a Benefit.	Not Covered
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$350	not a Benefit.	Not Covered
D6122	Implant supported retainer for metal FPD – noble alloys		$350	not a Benefit.	Not Covered
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$350	not a Benefit.	Not Covered
D6190	Radiographic/surgical implant index, by report		$75	not a Benefit.	Not Covered
D6191	Semi-precision abutment – placement		$350	not a Benefit.	Not Covered
D6192	Semi-precision attachment – placement		$350	not a Benefit.	Not Covered
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys		$265	not a Benefit.	Not Covered
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		$315	not a Benefit.	Not Covered
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		$95	not a Benefit.	Not Covered
D6198	Remove interim implant component		$110	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6199	Unspecified implant procedure, by report		$350	not a Benefit.	Not Covered
Prosthodontic, fixed (Major Services) Procedures (D6200-D6999)					
D6205	Pontic - indirect resin based composite	not a Benefit.	Not Covered	once per five years per tooth.	$165
D6210	Pontic - cast high noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6211	Pontic – cast predominately base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6212	Pontic - cast noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6214	Pontic – titanium and titanium alloys	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6240	Pontic – porcelain fused to high noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6241	Pontic – porcelain fused to predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6242	Pontic – porcelain fused to noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6243	Pontic – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6245	Pontic – porcelain/ceramic	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6250	Pontic – resin with high noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6251	Pontic – resin with predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6252	Pontic – resin with noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6545	Retainer – cast metal for resin bonded fixed prosthesis	not a Benefit.	Not Covered	once per five years per tooth.	$130
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	not a Benefit.	Not Covered	once per five years per tooth.	$145
D6549	Retainer – for resin bonded fixed prosthesis	not a Benefit.	Not Covered	not a Benefit.	Not Covered
D6608	Retainer onlay – porcelain/ceramic, two surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6610	Retainer onlay – cast high noble metal, two surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6611	Retainer onlay – cast high noble metal, three or more surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6612	Retainer onlay – cast predominantly base metal, two surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6614	Retainer onlay – cast noble metal, two surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6615	Retainer onlay – cast noble metal, three or more surfaces	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6634	Retainer onlay – titanium	not a Benefit.	Not Covered		$200
D6710	Retainer crown – indirect resin based composite	not a Benefit.	Not Covered	once per five years per tooth.	$200
D6720	Retainer crown – resin with high noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6721	Retainer crown – resin with predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6722	Retainer crown – resin with noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6740	Retainer crown – porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6750	Retainer crown – porcelain fused to high noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6751	Retainer crown – porcelain fused to predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6752	Retainer crown – porcelain fused to noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6781	Retainer crown – 3/4 cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6782	Retainer crown – 3/4 cast noble metal	not a Benefit.	Not Covered	once per five years per tooth.	$300
D6783	Retainer crown – 3/4 porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6784	Retainer crown 3/4 - titanium and titanium alloys	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6791	Retainer crown – full cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300	once per five years per tooth.	$300
D6794	Retainer crown – titanium and titanium alloys	not a Benefit.	Not Covered	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D6930	Re-cement or re-bond fixed partial denture	The original provider is responsible for all re-cementations within the first 12 months following the initial placement of a fixed partial denture. Not a Benefit within 12 months of a previous re-cementation by the same provider.	$40	once per six months per bridge.	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	not a Benefit within 12 months of initial placement or previous repair, same provider.	$95	once per 6-month period per bridge.	$95
D6999	Unspecified fixed prosthodontic procedure, by report		$350	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$400
Oral Maxillofacial Prosthetics Procedures (D7000-D7999)					
D7111	Extraction, coronal remnants – primary tooth	not a Benefit for asymptomatic teeth.	$40	once per tooth.	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	not a Benefit when removed by the same provider who performed the initial tooth extraction.	$65	once per tooth.	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	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.	$120	once per tooth.	$115
D7220	Removal of impacted tooth – soft tissue	a Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.	$95	once per tooth.	$85

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7230	Removal of impacted tooth – partially bony	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.	$145	once per tooth.	$145
D7240	Removal of impacted tooth – completely bony	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.	$160	once per tooth.	$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	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.	$175	once per tooth.	$175
D7250	Removal of residual tooth roots (cutting procedure)	a Benefit when the root is completely covered by alveolar bone. Not a Benefit to the same provider who performed the initial tooth extraction.	$80	once per tooth.	$75
D7260	Oroantral fistula closure	a Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.	$280	once per tooth per lifetime.	$280
D7261	Primary closure of a sinus perforation	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.	$285	not a Benefit.	Not Covered
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	once per arch regardless of the number of teeth involved and for permanent anterior teeth only.	$185		$185
D7280	Exposure of an unerupted tooth	not a Benefit: a. for Members age 21 or older, or b. for 3rd molars.	$220		$220

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7283	Placement of device to facilitate eruption of impacted tooth	only for Members in active orthodontic treatment. Not a Benefit: a. for Members age 21 years or older; and b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.	$85		$85
D7284	Excisional biopsy of minor salivary glands		$115		$115
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	for the removal of the specimen only and 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.	$180	not a Benefit.	Not Covered
D7286	Incisional biopsy of oral tissue – soft	for the removal of the specimen only and up to a maximum of 3 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	$110		$110
D7287	Exfoliative cytological sample collection	not a Benefit.	Not Covered		$35
D7288	Brush biopsy – transepithelial sample collection	not a Benefit.	Not Covered		$35
D7290	Surgical repositioning of teeth	for permanent teeth only; once per arch; and only for Members in active orthodontic treatment.	$185	not a Benefit.	Not Covered
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	once per arch and only for Members in active orthodontic treatment.	$80	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85	once per tooth per 36-month period. A Benefit when performed in conjunction with >4 extractions in the same area.	$85
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$50	once per tooth per 36-month period. A Benefit when performed in conjunction with >4 extractions in the same area.	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit regardless of the number of teeth or tooth spaces.	$120	once per tooth per 36-month period. Not a Benefit on same date of service as D7110-D7250.	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$65	once per tooth per 36-month period. Not a Benefit on same date of service as D7110-D7250.	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	once in a 5 year period per arch.	$350	not a Benefit.	Not Covered
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch. Not a Benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; and b. on the same date of service with extractions (D7111-D7250) same arch.	$350	not a Benefit.	Not Covered
D7410	Excision of benign lesion up to 1.25 cm		$75	not a Benefit.	Not Covered
D7411	Excision of benign lesion greater than 1.25 cm		$115	not a Benefit.	Not Covered
D7412	Excision of benign lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	$175	not a Benefit.	Not Covered
D7413	Excision of malignant lesion up to 1.25 cm		$95	not a Benefit.	Not Covered
D7414	Excision of malignant lesion greater than 1.25 cm		$120	not a Benefit.	Not Covered
D7415	Excision of malignant lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	$255	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm		$105	not a Benefit.	Not Covered
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm		$185	not a Benefit.	Not Covered
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		$180	once per site per lifetime.	$180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		$330	once per site per lifetime.	$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		$155	not a Benefit.	Not Covered
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		$250	not a Benefit.	Not Covered
D7465	Destruction of lesion(s) by physical or chemical method, by report		$40	not a Benefit.	Not Covered
D7471	Removal of lateral exostosis (maxilla or mandible)	once per quadrant and for the removal of buccal or facial exostosis only.	$140	one surgery per site per 36-month period.	$140
D7472	Removal of torus palatinus	once in the Member's lifetime.	$145	one surgery per site per 36-month period.	$140
D7473	Removal of torus mandibularis	once per quadrant.	$140	one surgery per site per 36-month period.	$140
D7485	Reduction of osseous tuberosity	once per quadrant.	$105	not a Benefit.	Not Covered
D7490	Radical resection of maxilla or mandible		$350	not a Benefit.	Not Covered
D7509	Marsupialization of odontogenic cyst		$180		$180
D7510	Incision and drainage of abscess – intraoral soft tissue	once per quadrant, same date of service.	$70	not a Benefit in conjunction with the extraction of same tooth (D7110-D7240) on same date of service.	$55
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	once per quadrant, same date of service.	$70	not a Benefit in conjunction with the extraction of same tooth (D7110-D7240) on same date of service.	$69
D7520	Incision and drainage of abscess – extraoral soft tissue		$70	not a Benefit.	Not Covered
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		$80	not a Benefit.	Not Covered
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).	$45	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).	$75	not a Benefit.	Not Covered
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per quadrant per date of service and 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).	$125	not a Benefit.	Not Covered
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket.	$235	not a Benefit.	Not Covered
D7610	Maxilla – open reduction (teeth immobilized, if present)		$140	not a Benefit.	Not Covered
D7620	Maxilla – closed reduction (teeth immobilized, if present)		$250	not a Benefit.	Not Covered
D7630	Mandible – open reduction (teeth immobilized, if present)		$350	not a Benefit.	Not Covered
D7640	Mandible – closed reduction (teeth immobilized, if present)		$350	not a Benefit.	Not Covered
D7650	Malar and/or zygomatic arch – open reduction		$350	not a Benefit.	Not Covered
D7660	Malar and/or zygomatic arch – closed reduction		$350	not a Benefit.	Not Covered
D7670	Alveolus – closed reduction, may include stabilization of teeth		$170	not a Benefit.	Not Covered
D7671	Alveolus – open reduction, may include stabilization of teeth		$230	not a Benefit.	Not Covered
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	for the treatment of simple fractures only.	$350	not a Benefit.	Not Covered
D7710	Maxilla – open reduction		$110	not a Benefit.	Not Covered
D7720	Maxilla – closed reduction		$180	not a Benefit.	Not Covered
D7730	Mandible – open reduction		$350	not a Benefit.	Not Covered
D7740	Mandible – closed reduction		$290	not a Benefit.	Not Covered
D7750	Malar and/or zygomatic arch – open reduction		$220	not a Benefit.	Not Covered
D7760	Malar and/or zygomatic arch – closed reduction		$350	not a Benefit.	Not Covered
D7770	Alveolus – open reduction stabilization of teeth		$135	not a Benefit.	Not Covered
D7771	Alveolus – closed reduction stabilization of teeth		$160	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7780	Facial bones – complicated reduction with fixation and multiple approaches	for the treatment of compound fractures only.	$350	not a Benefit.	Not Covered
D7810	Open reduction of dislocation		$350	not a Benefit.	Not Covered
D7820	Closed reduction of dislocation		$80	not a Benefit.	Not Covered
D7830	Manipulation under anesthesia		$85	not a Benefit.	Not Covered
D7840	Condylectomy		$350	not a Benefit.	Not Covered
D7850	Surgical discectomy, with/without implant		$350	not a Benefit.	Not Covered
D7852	Disc repair		$350	not a Benefit.	Not Covered
D7854	Synovectomy		$350	not a Benefit.	Not Covered
D7856	Myotomy		$350	not a Benefit.	Not Covered
D7858	Joint reconstruction		$350	not a Benefit.	Not Covered
D7860	Arthrotomy		$350	not a Benefit.	Not Covered
D7865	Arthroplasty		$350	not a Benefit.	Not Covered
D7870	Arthrocentesis		$90	not a Benefit.	Not Covered
D7871	Non-arthroscopic lysis and lavage		$150	not a Benefit.	Not Covered
D7872	Arthroscopy – diagnosis, with or without biopsy		$350	not a Benefit.	Not Covered
D7873	Arthroscopy – lavage and lysis of adhesions		$350	not a Benefit.	Not Covered
D7874	Arthroscopy – disc repositioning and stabilization		$350	not a Benefit.	Not Covered
D7875	Arthroscopy – synovectomy		$350	not a Benefit.	Not Covered
D7876	Arthroscopy – discectomy		$350	not a Benefit.	Not Covered
D7877	Arthroscopy – debridement		$350	not a Benefit.	Not Covered
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.	$120	not a Benefit.	Not Covered
D7881	Occlusal orthotic device adjustment		$30	not a Benefit.	Not Covered
D7899	Unspecified TMD therapy, by report	not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.	$350	not a Benefit.	Not Covered
D7910	Suture of recent small wounds up to 5 cm	not a Benefit for the closure of surgical incisions.	$35	not a Benefit.	Not Covered
D7911	Complicated suture – up to 5 cm	not a Benefit for the closure of surgical incisions.	$55	not a Benefit.	Not Covered
D7912	Complicated suture – greater than 5 cm	not a Benefit for the closure of surgical incisions.	$130	not a Benefit.	Not Covered
D7920	Skin graft (identify defect covered, location and type of graft)	not a Benefit for periodontal grafting.	$120	not a Benefit.	Not Covered
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site		$80	not a Benefit.	Not Covered
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation		$350	not a Benefit	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7940	Osteoplasty – for orthognathic deformities		$160	not a Benefit.	Not Covered
D7941	Osteotomy – mandibular rami		$350	not a Benefit.	Not Covered
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		$350	not a Benefit.	Not Covered
D7944	Osteotomy – segmented or subapical		$275	not a Benefit.	Not Covered
D7945	Osteotomy – body of mandible		$350	not a Benefit.	Not Covered
D7946	LeFort I (maxilla – total)		$350	not a Benefit.	Not Covered
D7947	LeFort I (maxilla – segmented)		$350	not a Benefit.	Not Covered
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft		$350	not a Benefit.	Not Covered
D7949	LeFort II or LeFort III – with bone graft		$350	not a Benefit.	Not Covered
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	not a Benefit for periodontal grafting.	$190	not a Benefit.	Not Covered
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	only for Members with authorized implant services.	$290	not a Benefit.	Not Covered
D7952	Sinus augmentation via a vertical approach	only for Members with authorized implant services.	$175	not a Benefit.	Not Covered
D7955	Repair of maxillofacial soft and/or hard tissue defect	not a Benefit for periodontal grafting.	$200	not a Benefit.	Not Covered
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	not a Benefit.	Not Covered		$145
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	not a Benefit.	Not Covered		$175
D7961	Buccal / labial frenectomy (frenulectomy)	once per arch per date of service and only when the permanent incisors and cuspids have erupted.	$120	once per site per lifetime.	$120
D7962	Lingual frenectomy (frenulectomy)	once per arch per date of service and only when the permanent incisors and cuspids have erupted.	$120	once per site per lifetime.	$120
D7963	Frenuloplasty	once per arch per date of service and only when the permanent incisors and cuspids have erupted. Not a Benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.	$120	once per site per lifetime.	$120
D7970	Excision of hyperplastic tissue – per arch	once per arch per date of service.	$175	once per site per 36-month period.	$176
D7971	Excision of pericoronal gingiva		$80	once per site per lifetime.	$80

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.	$100	not a Benefit.	Not Covered
D7979	Non-surgical sialolithotomy		$155	not a Benefit.	Not Covered
D7980	Surgical sialolithotomy		$155	not a Benefit.	Not Covered
D7981	Excision of salivary gland, by report		$120	not a Benefit.	Not Covered
D7982	Sialodochoplasty		$215	not a Benefit.	Not Covered
D7983	Closure of salivary fistula		$140	not a Benefit.	Not Covered
D7990	Emergency tracheotomy		$350	not a Benefit.	Not Covered
D7991	Coronoidectomy		$345	not a Benefit.	Not Covered
D7995	Synthetic graft – mandible or facial bones, by report	not a Benefit for periodontal grafting.	$150	not a Benefit.	Not Covered
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers.	$60	not a Benefit.	Not Covered
D7999	Unspecified oral surgery procedure, by report		$350	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	$350
Orthodontics Procedures (D8000-D8999)					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).	$350	not a Benefit.	Not Covered
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.		not a Benefit.	Not Covered
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.		not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D8660	Pre-orthodontic treatment examination to monitor growth and development	once every 3 months for a maximum of 6 and must be done 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.		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit - handicapping malocclusion	once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit 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).		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit cleft palate - 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).		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit cleft palate - 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)		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit 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).		not a Benefit.	Not Covered
D8670	Periodic orthodontic treatment visit facial growth management - 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).		not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D8670	Periodic orthodontic treatment visit facial growth management - 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).		not a Benefit.	Not Covered
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).		not a Benefit.	Not Covered
D8681	Removable orthodontic retainer adjustment			not a Benefit.	Not Covered
D8696	Repair of orthodontic appliance – maxillary	once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.		not a Benefit.	Not Covered
D8697	Repair of orthodontic appliance – mandibular	once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.		not a Benefit.	Not Covered
D8698	Re-cement or re-bond fixed retainer – maxillary	once per provider.		not a Benefit.	Not Covered
D8699	Re-cement or re-bond fixed retainer – mandibular	once per provider.		not a Benefit.	Not Covered
D8701	Repair of fixed retainer, includes reattachment – maxillary			not a Benefit.	Not Covered
D8702	Repair of fixed retainer, includes reattachment – mandibular			not a Benefit.	Not Covered
D8703	Replacement of lost or broken retainer – maxillary	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).		not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D8704	Replacement of lost or broken retainer – mandibular	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).		not a Benefit.	Not Covered
D8999	Unspecified orthodontic procedure, by report			not a Benefit.	Not Covered
Adjunctive General Services (D9000-D9999)					
D9110	Palliative treatment of dental pain – per visit	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.	$30	once per month for same condition.	$28
D9120	Fixed partial denture sectioning	a Benefit when at least one of the abutment teeth is to be retained.	$95		$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures	once per date of service per provider and 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.	$10	two per visit.	$10
D9211	Regional block anesthesia		$20		$20
D9212	Trigeminal division block anesthesia		$60		$60
D9215	Local anesthesia in conjunction with operative or surgical procedures		$15		$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia		$45		$45

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D9222	Deep sedation/general anesthesia - first 15 minutes	Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$45		$45
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		$45	maximum of additional 30 minutes per visit.	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$15	not a Benefit.	Not Covered
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	Not a benefit: a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$60	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	not a Benefit: a. 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); and b. when all associated procedures on the same date of service by the same provider are denied.	$60	maximum of additional 30 minutes per visit.	$45
D9248	Non-intravenous conscious sedation	once per date of service; for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9243); and b. when all associated procedures on the same date of service by the same provider are denied.	$65	not a Benefit.	Not Covered
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		$50	once per year for the same condition.	$45
D9311	Consultation with a medical health professional		No Charge		No Charge
D9410	House/extended care facility call	once per Member per date of service and only in conjunction with procedures that are payable.	$50	not a Benefit.	Not Covered
D9420	Hospital or ambulatory surgical center call	a Benefit for each hour or fraction thereof as documented on the operative report.	$135	not a Benefit.	Not Covered

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	once per date of service per provider. Not a Benefit: a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service; and b. for visits to Members residing in a house/ extended care facility.	$20	once per month.	$12
D9440	Office visit – after regularly scheduled hours	once per date of service per provider and only with treatment that is a Benefit.	$45	once per month.	$40
D9450	Case presentation, subsequent to detailed and extensive treatment planning	not a Benefit.	Not Covered	integral to D0120, D0160, D0140, D0170 and D0150 and not a separate billable item	No Charge
D9610	Therapeutic parenteral drug, single administration	up to a maximum of 4 injections per date of service. Not a Benefit: a. 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 (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$30	not a Benefit.	Not Covered
D9612	Therapeutic parenteral drugs, two or more administrations, different medications		$40	not a Benefit.	Not Covered
D9910	Application of desensitizing medicament	once in a 12 month period per provider and for permanent teeth only.	$20	two (2) applications on any number of teeth per 12-month period.	$22

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	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; and for the removal of bony fragments within 30 days of the date of service of an extraction. Not a Benefit: a. for the removal of bony fragments on the same date of service as an extraction; and b. for routine post- operative visits.	$35	not a Benefit.	Not Covered
D9942	Repair and/or reline of occlusal guard	not a Benefit.	Not Covered	once per 12-month period.	$35
D9943	Occlusal guard adjustment	not a Benefit.	Not Covered	once per 12-month period (6 months after initial placement).	$35
D9944	Occlusal guard – hard appliance, full arch	not a Benefit.	Not Covered	once per 2 years, Not a Benefit for TMJ pain or treatment.	$115
D9945	Occlusal guard – soft appliance, full arch	not a Benefit.	Not Covered	once per 2 years, Not a Benefit for TMJ pain or treatment.	$115
D9946	Occlusal guard – hard appliance, partial arch	not a Benefit.	Not Covered	once per 2 years, Not a Benefit for TMJ pain or treatment.	$115
D9950	Occlusion analysis – mounted case	once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ dysfunction only; and for permanent dentition. Not a Benefit for bruxism only.	$120	not a Benefit.	Not Covered
D9951	Occlusal adjustment – limited	once in a 12 month period per quadrant per provider; for Members age 13 and older; and 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.	$45	once per 12-month period.	$45

Code	Description	Pediatric Limitation	Pediatric Cost Share	Adult Limitation	Adult Cost Share
D9952	Occlusal adjustment – complete	once in a 12 month period following occlusion analysis-mounted case (D9950); for Members age 13 and older; for diagnosed TMJ dysfunction only; and for permanent dentition.	$210	once per 12-month period.	$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	shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	No Charge

(Intentionally left blank)