Evidence of Coverage

and Disclosure Statement

Group Dental Plan

Plan Name: Custom HN Value DHMO 115

University of California Postdoctoral Scholar Benefit Plan

Benefits provided by Dental Benefit Providers of California, Inc.

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Evidence of Coverage provides a detailed summary of how your dental plan operates, your entitlements, and the plan's restrictions and limitations.

However, this combined Evidence of Coverage and Disclosure Statement constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

You may obtain a copy of the health plan contract by requesting it from your Organization, or by writing to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704, or by calling **(866) 249-2382**.

This Evidence of Coverage and Disclosure Statement is subject to Chapter 2.2 of Division 2 of the California Health and Safety Code (commonly referred to as the Knox-Keene Act) and the regulations issued thereto by the Department of Managed Health Care. Should either the law or the regulations be amended, such amendments shall automatically be deemed to be a part of this document and shall take precedence over any inconsistent provision of this contract. Any provision required to be in this Evidence of Coverage and Disclosure Statement by either law or the regulation shall automatically bind DBP.

Entire Contract

We typically contract with an Organization, such as your employer or association, to offer benefits to its employees or members. Your Organization's contract, together with the application, acceptance agreement, Enrollment Form, this Evidence of Coverage and any attachments or inserts including the Schedule of Benefits with Exclusions and Limitations, constitutes the entire agreement between the parties. To be valid, any change in the contract must be approved by us and attached to it. No agent may change the Contract or waive any of the provisions. Should any provision herein not conform to applicable laws, it shall be construed as if it were in full compliance thereof.

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

Health Net Dental DHMO plans are provided by Dental Benefit Providers of California, Inc. ("DBP"). Obligations of DBP are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

Evidence of Coverage and Disclosure Statement

Table of Contents

Who May Enroll

Your Organization determines how you may become eligible to join the Plan. You may enroll yourself and your dependents, provided each meets your Organization's eligibility requirements and/or the Service Area and Dependent Coverage requirements listed below.

Service Area

The Service Area is the geographical area in which we have a panel of Selected General Dentists and Specialists who have agreed to provide care to our members. To enroll, you must reside, live, or work in the Service Area, and the permanent legal residence of any enrolled dependents must be:

- The same as yours;
- In the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where the Subscriber has legal responsibility for the health care of such dependents;
- In the Service Area under other circumstances where you are legally responsible for the health care of such dependents; or
- In the Service Area with your spouse.

Dependent Coverage

Your Organization is responsible for determining dependent eligibility. In the absence of such a determination, we define eligible dependents to be:

- Your lawful spouse or registered domestic partner. Benefits may be available for unregistered domestic partners if your Organization permits such coverage.
- Your unmarried children or grandchildren up to age 25 for whom you provide care (including adopted children, step-children, or other children for whom you are required to provide dental care pursuant to a court or administrative order).
- Your children who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition. At least 90 days prior to a disabled dependent reaching the limiting age, DBP will send notice to you, the Subscriber, that coverage for the disabled dependent will terminate at the end of the limiting age, unless proof of such incapacity and dependency is provided to DBP within 60 days of receipt of notice.
- Other dependents if your Organization provides benefits for these dependents.

Please check with your Organization if you have questions regarding your eligibility requirements.

When Coverage Begins

Coverage for you and your enrolled dependents will begin on the date determined by your Organization. Newborn children are covered the first day of the month following the date of birth and legally adopted children, foster children and stepchildren are covered the first day of the month following placement as long as we are notified within thirty (30) days and any prepayment fee is paid within that period.

Check with your Organization if you have any questions about when your coverage begins.

Choice of Provider

When you enroll, you and each enrolled family member must choose a Selected General Dentist from our network. Each family member may select a different dental office. Please refer to the Directory of Participating Dentists for a complete listing of Selected General Dentists.

Facilities

A complete list of contracted facilities is contained in the Provider Directory. You may obtain an updated Provider Directory by calling **(866) 249-2382** or at www.yourdentalplan.com/healthnet.

New Patient and Routine Services

As a member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the Selected General Dentist may need additional time to meet your special request.

Making an Appointment

Once your coverage begins, you may contact the Selected General Dentist you selected at enrollment to schedule an appointment. Selected General Dentists' offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as a member. Your Selected General Dentist will also need to know your chief dental concern and basic personal data. Arrive early for your first appointment to complete any paperwork. There is an office visit co-payment on some plans and also be aware that there is a charge for missing your appointment. Your first visit to your dentist will usually consist of x-rays and an examination only. By performing these procedures first, your dentist can establish your treatment plan according to your overall health needs.

We recommend that you take this brochure with you on your appointment, along with the enclosed Schedule of Benefits. Remember, only dental services listed as covered benefits in the Schedule of Benefits and provided by a Selected General Dentist are covered.

Specialist Referrals

During the course of treatment, you may require the services of a Specialist. Your Selected General Dentist will submit all required documentation to us and we will advise you of the name, address, and telephone number of the Specialist who will provide the required treatment. These services are available only when the dental procedure cannot be performed by the Selected General Dentist due to the severity of the problem. Some plans require that specialty referrals be authorized in writing, while others incorporate a direct or self-referral process. Full information is contained in your plan Schedule of Benefits.

Changing Your Selected General Dentist

You have control over your choice of dental offices, and you can make changes at any time. If you would like to change your Selected General Dentist, please contact Customer Service at **(866) 249-2382**. Our associates will help you locate a dental office most convenient to you. The transfer will be effective on the first day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

Second Opinions

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. Contact our Customer Service Department either by calling **(866) 249-2382** or sending a written request to the following address:

Health Net Dental

c/o Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

In addition, your Selected General Dentist may also request a second opinion on your behalf. There is no second opinion consultation charge to you. You will be responsible for the office visit co-payment as listed on your Schedule of Benefits.

Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If you question the reasonableness or necessity of recommended surgical procedures.

(2) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

Requests for second opinions are processed within five (5) business days of receipt of such request, except when an expedited second opinion is warranted; in which case a decision will be made and conveyed to you within 24 hours. Upon approval, we will contact the consulting dentist and make arrangements to enable you to schedule an appointment. All second opinion consultations will be completed by a contracted dentist with qualifications in the same area of expertise as the referring dentist or dentist who provided the initial examination or dental care services. You may obtain a copy of the second dental opinion policy by contacting our Customer Service Department by telephone at the toll-free number indicated above, or by writing to us at the above address.

No co-payment is required for a second opinion consultation. Some plans do require a co-payment for an office visit.

Your Financial Responsibility:

Prepayment Fee

Your Organization prepays your coverage on a monthly basis. If you are responsible for any portion of this prepayment fee, your Organization will advise you of the amount and how it is to be paid. Please refer to the copayment section, below, for information relating to your co-payments under this plan. The prepayment fee is not the same as a co-payment.

The exact premium charge is contained in the health plan contract between DBP and your Organization. You may obtain a copy of the health plan contract from your Organization, or by writing to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704, or by calling **(866) 249-2382**

Co-payments

When you receive care from either a Selected General Dentist or Specialist, you will pay the co-payment described on your Schedule of Benefits enclosed with this Evidence of Coverage. When you are referred to a Specialist, your co-payment may be either a fixed dollar amount, or a percentage of the dentist's usual and customary fee. Please refer to the Schedule of Benefits for specific details. When you have paid the required co-payment, if any, you have paid in full. If we fail to pay the contracted provider, you will not be liable to the provider for any sums owed by us. If you choose to receive services from a non-contracted provider, you may be liable to the non-contracted provider for the cost of services unless specifically authorized by us or in accordance with emergency care provisions. We do not require claim forms.

Other Charges

All other charges you may be required to pay under this plan are listed in the Schedule of Benefits.

Coordination of Benefits

We do not coordinate benefits with any other carrier. If you have coverage with another carrier, please contact that carrier to determine whether coordination of benefits is available.

Customer Service

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your dental office. Customer Service can be reached Monday through Friday at **(866) 249-2382** from 5:00 a.m. to 6:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and dental office transfers.

Emergency Dental Services

Emergency dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a reasonably prudent lay person possessing average knowledge of dentistry to believe that immediate care is needed.

All Selected General Dentists provide emergency dental services twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your Selected General Dentist. **If you require emergency dental services, you may go to any dental provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior Authorization for emergency dental services is not required.**

Your reimbursement from us for emergency dental services, if any, is limited to the extent the treatment you received directly relates to emergency dental services - i.e. to evaluate and stabilize the dental condition. All reimbursements will be allocated in accordance with your plan benefits, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any hospital or outpatient care facility that are not related to treatment of the actual dental condition are not covered benefits.

If you receive emergency dental services, you will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. If you seek emergency dental services from a provider

located more than 25 miles away from your Selected General Dentist, you will receive emergency benefits coverage up to a maximum of $50, less any applicable co-payments.

To be reimbursed for emergency dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement.

If you do not require emergency dental services and a delay in receiving treatment would not be detrimental to your health, please contact your Selected General Dentist or our Customer Service Department at **(866) 249-2382** to make reasonable arrangements for your care.

Grievance Procedures

If you or one of your eligible dependents has a grievance with us or your dentist, you may orally submit such grievance by calling our Customer Service Department at **(866) 249-2382**. We will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number) or a detailed summary of your grievance to:

Health Net Dental

c/o Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

Please be sure to include your name (patient's name, if different), Member Identification Number, facility (or Selected General Dentist) name and number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the plan. We will confirm receipt of your complaint in writing within five (5) calendar days of receipt. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

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 1-866-249-2382 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review

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

In the event of an urgent grievance, which involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, you are not required to participate in our grievance process and may directly contact the California Department of Managed Health Care, as referenced above, for review of the urgent grievance.

Arbitration

Each and every disagreement, dispute or controversy which remains unresolved concerning the construction, interpretation, performance or breach of this contract, or the provision of dental services under this contract after exhausting our complaint procedures, arising between the organization, a member or the heir-at-law or personal representative of such person, as the case may be, and our company, its employees, officers or directors, or participating dentist or their dental groups, partners, agents, or employees, shall be submitted to binding arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this contract but which gives rise to a claim after the termination of this contract. Arbitration shall be initiated by written notice to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704. The notice shall include a detailed description of the matter to be arbitrated.

BY PARTICIPATING IN THE PLAN, YOU AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE AND/OR OTHER DISPUTES RELATED TO THE DELIVERY OF SERVICES UNDER THE PLAN DECIDED BY NEUTRAL, BINDING ARBITRATION PURSUANT TO THE TERMS OF THE CONTRACT, AND YOU GIVE UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Changes To Your Coverage:

Termination of Benefits

Your coverage may be cancelled for any reason, after not less than 60 days written notice by either us or your Organization.

Your coverage may be cancelled after not less than 30 days written notice for:

- Failure to establish a satisfactory dentist-patient relationship and if it is shown that DBP has, in good faith, provided you with the opportunity to select an alternative dentist.
- Neither residing, living, or working in the service area or area for which DBP is authorized to do business.

Your coverage may be cancelled after not less than 15 days written notice for:

- An intentional misrepresentation, except as limited by statute.

- Fraud in the use of services or facilities, or on the part of the Organization.
- Such other good cause as is agreed upon in the contract.

Your coverage may be cancelled immediately:

- For non-payment of amounts due under the contract, if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
- Subject to continuation of coverage and conversion privilege provisions, if applicable, if you do not meet eligibility requirements other than the requirements that you live or work in the service area.
- For any misconduct detrimental to safe plan operations and the delivery of services.
- Upon termination of the health plan contract between us and your Organization, if expired and not renewed.

If your Organization fails to pay the prepayment fees through and including the final month of the contract, all coverage may be terminated at the end of the grace period, and you may be responsible for the usual and customary fees for any services received from your Selected General Dentist or Specialist during the period the prepayment fees went unpaid, including the grace period.

If you terminate from the plan while the contract between us and your Organization is in effect, your coverage will extend to the end of the month following notice of termination. Your Selected General Dentist must complete any dental procedure started on you before your termination, abiding by the terms and conditions of the plan.

Enrollment will be cancelled as of the last day for which payment has been received, subject to compliance with notice requirements.

In the event your enrollment is cancelled, we will send such notification to your Organization, which will, in turn, notify you. Your Organization will also send you notice when your actual coverage is terminated.

Orthodontic treatment is governed by the orthodontic limitations listed on your schedule of benefits. If you terminate coverage from the plan after the start of orthodontic treatment, you will be responsible for any additional incurred charges for any remaining orthodontic treatment.

Renewal Provisions

Your Organization has contracted with us to provide services for the time period specified in the contract between the parties. Your coverage under the plan is guaranteed for that time period so long as you meet the eligibility requirements under the plan. When the contract expires, it may be renewed. If renewed, it is possible that the terms of the plan may have been changed. If changes to benefits, co-payments or premiums have been made to a renewed contract, your Organization will notify you not less than thirty (30) days before the effective date.

Reinstatement

Receipt by us of the proper prepaid or periodic payment after cancellation of the contract for non-payment shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding payment.

An enrollee or subscriber who alleges that his or her enrollment has been canceled or not renewed because of his or her health status or requirements for health care services may request a review by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists, the Director shall notify us. Within 15 days after receipt of such notice, we shall either request a hearing or reinstate the enrollee or subscriber. If, after a hearing, the Director determines that the cancellation or failure to renew is improper, the Director shall order us to reinstate the enrollee or

subscriber. A reinstatement pursuant to this provision shall be retroactive to the time of cancellation or failure to renew and we shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date or reinstatement.

Conversion Privilege

Contact our Customer Service Department at **(866) 249-2382** to check availability of a conversion plan in your area.

Continuity of Care:

Current Members

Current members may have the right to the benefit of completion of care with their Terminated Provider for certain specified dental conditions. Please call us at **(866) 249-2382** to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your Terminated Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Terminated Provider on the terms regarding your care in accordance with California law.

New Members

New members may have the right to the benefit of completion of care with their Non-Participating Provider for certain specified dental conditions. Please call us at **(866) 249-2382** to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your Non-Participating Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Non-Participating Provider on the terms regarding your care in accordance with California law. This policy does not apply to new members of an individual subscriber contract.

You may obtain a copy of our policy on continuation of care, which contains the specific information relating to the required qualifying events for receiving continuation of care, or you may receive information regarding your rights to continuation of care from our Customer Service Department by calling **(866) 249-2382**. If you have further questions, you are encouraged to contact the California Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov.

Individual Continuation of Benefits

You and your eligible dependents may be eligible to retain coverage in accordance with COBRA (Consolidated Omnibus Budget Reconciliation Act) and/or Cal-COBRA (California Continuation of Benefits Replacement Act) requirements. You and your dependents may also be eligible for Medicare benefits. If you go through a divorce or legal separation, have your hours reduced, have a death in the family, or have a child who is no longer an eligible dependent, you must notify your employer or you will lose your right to continued coverage. For COBRA qualifying events, you must notify your employer within 60 days. For Cal-COBRA, you must notify your employer within 30 days. Failure to make such notification within the required time period will disqualify you from receiving continuation coverage. See your Organization for more details.

Upon election, you will be able to continue this plan, subject to the terms and conditions of the Organization contract and the requirements of COBRA or Cal-COBRA.

The continuation of your coverage will only be provided for the balance of the period that you would have remained covered under your prior plan.

Member Rights

During the term of the contract between us and your Organization, we guarantee that it will not decrease any benefits, increase any co-payment, or change any exclusion or limitation. We will not cancel or fail to renew your enrollment in this Plan because of your health condition or your requirements for dental care. Your Selected General Dentist is responsible to you for all treatment and services, without interference from us.

However, your Selected General Dentist must follow the rules and limitations set up by us and conduct his or her professional relationship with you within the guidelines established by us. If our relationship with your Selected General Dentist ends, your dentist is obligated to complete any and all treatment in progress. We will arrange a transfer for you to another dentist to provide for continued coverage under the Plan. As indicated on your enrollment form, your signature authorizes us to obtain copies of your dental records, if necessary.

As a member, you have the right to...

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality.
- Express complaints and be informed of the complaint process.
- Have access and availability to care and access to and copies of your dental records.
- Participate in decision-making regarding your course of treatment.
- Be provided information regarding Selected General Dentists.
- Be provided information regarding the services, benefits and specialty referral process.

Member Responsibilities

As a member, you have the responsibility to...

- Identify yourself to your Selected General Dentist as a member. If you fail to do so, you may be charged the dentist's usual and customary fees instead of the applicable co-payment, if any.
- Treat the dentist and his or her office staff with respect and courtesy and cooperate with the prescribed course of treatment. If you continually refuse a prescribed course of treatment, your Selected General Dentist or Specialist has the right to refuse to treat you. We will facilitate second opinions and will permit you to change your Selected General Dentist; however, we will not interfere with the dentist-patient relationship and cannot require a particular dentist to perform particular services.
- Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.
- Make co-payments at the time of service. If you do not, the dentist may collect those co-payments from you at subsequent appointments and in accordance with their policies and procedures.
- Notify us of changes in family status. If you do not, we will be unable to authorize dental care for you and/or your family members.
- Be aware of and follow your Organization's guidelines in seeking dental care. If you do not, your Organization may not have sufficient information to report your eligibility to us, which could result in a denial of care.

Public Policy Committee

The Public Policy Committee provides our clients with the opportunity to participate in the review of quality improvement activities. Representatives of organizations such as yours, contracting dentists, and our staff Members, meet quarterly to discuss quality improvement activities and policies. If you are interested in being a representative to the Committee meeting, please contact us at **(866) 249-2382** and ask for the Director of Quality Management.

Language Assistance

As a DBP member you have a right to free language assistance services, including oral interpretation and, for some documents, translation services in most frequently spoken languages. DBP collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform DBP of your preferred language, please contact DBP at **(866) 249-2382** or via our online website at www.healthnet.com.

Como miembro de DBP, usted tiene derecho a recibir servicios de ayuda en otros idiomas en forma gratuita, incluyendo interpretación oral y, para ciertos documentos, servicios de traducción en los idiomas que se hablan con más frecuencia. DBP recopila y mantiene sus preferencias de idioma, raza y origen étnico para que podamos comunicarnos con más eficacia con nuestros miembros. Si necesita ayuda en otros idiomas o desea informar a DBP cuál es su idioma preferido, comuníquese con DBP al **(866) 249-2382** o a través de nuestro sitio de Internet en línea en www.healthnet.com.

身為 DBP 會員，您有權利取得免費語言協助服務，包括多數常用語言的口譯服務及部份文件的書面翻譯服務。DBP 查並記錄您的語言偏好、種族與民族，以增進與會員間溝通的效率。若您需要語言協助或希望將您的語言偏好通知 DBP，請致電 (866) 249-2382 與 DBP 聯絡，或至網站 www.healthnet.com.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are non-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 each service. If you would like more information about dental coverage options, you may call member services at **(866) 249-2382** or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

For purposes of this section, “covered services” or “covered dental services” means dental care services for which the plan is obligated to pay pursuant to an enrollee’s plan contract, or for which the plan would be obligated to pay pursuant to an enrollee’s plan contract but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations or alternative benefit payments.

A member's loss of program eligibility and disenrollment from the plan. Reason for termination of benefits may be termination of the group contract, termination of the subscriber's employment with the Organization or dependent status change as set forth herein.

The following definitions are used in this Evidence of Coverage.

Arbitration

A non-court proceeding which is used to solve legal disputes. It is usually held before an attorney or judge who weighs the evidence and renders a binding decision, which has the force of law. Arbitration is an efficient alternative to a trial court proceeding for resolving legal disputes.

Co-payment

The amount listed on the Schedule of Benefits for covered services that the member is required to pay at the time of treatment.

Dental Records

A single complete record kept at the site of your dental care. Dental records refers to diagnostic aids, such as intraoral and extra-oral radiographs, written treatment records including, but not limited to, progress notes, dental or periodontal chartings, treatment plans, specialty referrals, consultation reports or other written material relating to an individual's medical and dental history, diagnosis, condition, treatment and/or evaluation.

Dependent

Eligible family members of a subscriber who is enrolled in the dental plan. (See Dependent Coverage).

Emergency Dental Services

Dental services rendered for the relief of acute pain, bleeding, infection, fever, or for conditions that may result in disability or death, and where delay of treatment would be medically unadvisable.

Medically Necessary

Covered services that are necessary and meet with professionally recognized standards of practice. The fact that a dentist may prescribe, order, recommend or approve a service or material does not, in itself make it medically necessary, or make it a covered service and material even though it is not listed in this Policy or the Schedule of Benefits as an exclusion.

Member

An individual enrolled in the dental plan.

Non-Participating Provider

A dentist who has no contract to provide services for the Plan.

Organization

An employer or other entity that has contracted with us to arrange for the provision of dental care benefits.

Plan

Coverage for specified dental care services purchased by an Organization for its members for a fixed, periodic payment made in advance of treatment. Such plans often include the use of fixed co-payments to clarify the financial obligation of covered dental care, and are subject to Exclusions and Limitations.

Prepayment Fee

The monthly fee paid to us by your Organization. The prepayment fee is not the same as a co-payment.

Provider

A dentist providing services under contract with the Plan.

Selected General Dentist

A contracted dentist who agrees in writing to provide dental services under special terms, conditions and financial reimbursement arrangements with us.

Service Area

The Service Area is the geographical area in which there is a panel of Selected General Dentists and specialists who have agreed to provide care to members.

Subscriber

The person, usually the employee, who represents the family unit in relation to the dental benefit program. Also known as: certificate holder, enrollee.

Terminated Provider

A dentist who formerly delivered services under contract that is no longer associated with the Plan.

Termination of Benefits

A member's loss of program eligibility and disenrollment from the plan. Reason for termination of benefits may be termination of the group contract, termination of the subscriber's employment with the Organization or dependent status change as set forth herein.

Benefit Schedule

HN Value DHMO 115

This document describes the Covered Services of this dental plan, as well as Co-payment requirements, Limitations of Benefits and Exclusions. Covered Services are also subject to the terms and conditions stated in the Evidence of Coverage and the Group Agreement. The Evidence of Coverage is written in generic form to describe the provisions which are common to a number of different plan variations. If there are any inconsistencies in the provision of the Evidence of Coverage and this Benefit Schedule, the provisions of the Benefit Schedule shall govern. Except for Emergency Dental Care as described in the Evidence of Coverage and Orthodontia as described below, all of the following services must be provided by the Member's Primary Dentist in order to be Covered Services under this dental plan unless prior approval is obtained for referral to a specialist. For more information, visit www.yourdentalplan.com/healthnet.

Benefits provided by Dental Benefit Providers of California, Inc.

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0

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Code	Service	Member Co-payment
D0350	Oral/facial photographic images	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$15
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	$0

Preventive

D1110	Prophylaxis - adult	$0
D1110	Prophylaxis - adult (in addition to one allowed every six months)	$40
D1120	Prophylaxis - child	$0
D1120	Prophylaxis - child (in addition to one allowed every six months)	$25
D1201	Topical application of fluoride (including prophylaxis) - child	$0
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	$0
D1205	Topical application of fluoride (including prophylaxis) - adult	$0
D1310	Nutritional counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$20
D1515	Space maintainer - fixed - bilateral	$20
D1520	Space maintainer - removable - unilateral	$20
D1525	Space maintainer - removable - bilateral	$20
D1550	Re-cementation of space maintainer	$5

Restorative

D2140	Amalgam - one surface, primary or permanent	$0

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Member Services (866) 249-2382

Code	Service	Member Co-payment
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$0
D2331	Resin-based composite - two surfaces, anterior	$0
D2332	Resin-based composite - three surfaces, anterior	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite - one surface, posterior (primary)	$15
D2392	Resin-based composite - two surfaces, posterior (primary)	$20
D2393	Resin-based composite - three surfaces, posterior (primary)	$30
D2394	Resin-based composite - four or more surfaces, posterior (primary)	$30
D2391	Resin-based composite - one surface, posterior	$65
D2392	Resin-based composite - two surfaces, posterior	$75
D2393	Resin-based composite - three surfaces, posterior	$80
D2394	Resin-based composite - four or more surfaces, posterior	$80
D2510	Inlay - metallic - one surface*	$115
D2520	Inlay - metallic - two surfaces*	$115
D2530	Inlay - metallic - three or more surfaces*	$115
D2542	Onlay - metallic - two surfaces*	$115
D2543	Onlay - metallic - three surfaces*	$115
D2544	Onlay - metallic - four or more surfaces*	$115

Crowns - Single Restorations Only

D2740	Crown - porcelain/ceramic substrate	$225
D2740	Crown - porcelain/ceramic substrate (Leucite-reinforced pressed crown/Empress)	Co-payment + $300
D2750	Crown - porcelain fused to high noble metal*	$115

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Member Services (866) 249-2382

Code	Service	Member Co-payment
D2750	Crown - porcelain fused to high noble metal (gold composite reinforced crown/Captek)	Co-payment + $300
D2751	Crown - porcelain fused to predominantly base metal	$115
D2752	Crown - porcelain fused to noble metal*	$115
D2780	Crown - 3/4 cast high noble metal*	$115
D2781	Crown - 3/4 cast predominantly base metal	$115
D2782	Crown - 3/4 cast noble metal*	$115
D2783	Crown - 3/4 porcelain/ceramic	$115
D2790	Crown - full cast high noble metal*	$115
D2791	Crown - full cast predominantly base metal	$115
D2792	Crown - full cast noble metal*	$115
D2794	Crown - titanium	$115
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2940	Sedative filling	$0
D2950	Core buildup, including any pins*	$15
D2951	Pin retention - per tooth, in addition to restoration*	$10
D2952	Cast post and core in addition to crown*	$25
D2953	Each additional cast post - same tooth*	$25
D2954	Prefabricated post and core in addition to crown	$25
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2970	Temporary crown (fractured tooth)	$0

Endodontics

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0

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Code	Service	Member Co-payment
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3222	Partial Pulpotomy for apexogenesis-permanent tooth with incomplete root development	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$10
D3310	Anterior (excluding final restoration)	$70
D3320	Bicuspid (excluding final restoration)	$80
D3330	Molar (excluding final restoration)	$150
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3346	Retreatment of previous root canal therapy - anterior	$80
D3347	Retreatment of previous root canal therapy - bicuspid	$100
D3348	Retreatment of previous root canal therapy - molar	$200
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy/periradicular surgery - anterior	$90
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$90
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100
D3426	Apicoectomy/periradicular surgery (each additional root)	$90
D3430	Retrograde filling - per root	$90
D3450	Root amputation - per root	$95
D3920	Hemisection (including any root removal), not including root canal therapy	$90

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Code	Service	Member Co-payment
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$35
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$35
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$150
D4249	Clinical crown lengthening - hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$275
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$275
D4270	Pedicle soft tissue graft procedure	$300
D4271	Free soft tissue graft procedure (including donor site surgery)	$300
D4273	Subepithelial connective tissue graft procedures	$300
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	$25
D4342	Periodontal scaling and root planing - one to three teeth - per quadrant	$25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$15
D4999	Periodontal charting for planning treatment of periodontal disease	$0
Prosthodontics (Removable)		
D5110	Complete denture - maxillary	$125
D5110	Complete denture - maxillary (Comfort Flex (complete upper denture) acetyl resin homopolymer)	Co-payment + $400
D5120	Complete denture - mandibular	$125

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Code	Service	Member Co-payment
D5120	Complete denture - mandibular (Comfort Flex (complete lower denture) acetyl resin homopolymer)	Co-payment + $400
D5130	Immediate denture - maxillary	$125
D5130	Immediate denture - maxillary (Comfort Flex (complete upper denture) acetyl resin homopolymer)	Co-payment + $400
D5140	Immediate denture - mandibular	$125
D5140	Immediate denture - mandibular (Comfort Flex (complete lower denture) acetyl resin homopolymer)	Co-payment + $400
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$150
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) (Comfort Flex (upper partial denture) acetyl resin homopolymer)	Co-payment + $425
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$150
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) (Comfort Flex (lower partial denture) acetyl resin homopolymer)	Co-payment + $425
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$175
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (upper partial denture) acetyl resin homopolymer)	Co-payment + $425
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$175
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (lower partial denture) acetyl resin homopolymer)	Co-payment + $425
D5410	Adjust complete denture - maxillary	$10
D5411	Adjust complete denture - mandibular	$10
D5421	Adjust partial denture - maxillary	$10
D5422	Adjust partial denture - mandibular	$10
D5510	Repair broken complete denture base	$15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15
D5610	Repair resin denture base	$15

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Code	Service	Member Co-payment
D5620	Repair cast framework	$15
D5630	Repair or replace broken clasp	$15
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$15
D5660	Add clasp to existing partial denture	$15
D5710	Rebase complete maxillary denture	$50
D5711	Rebase complete mandibular denture	$50
D5720	Rebase maxillary partial denture	$50
D5721	Rebase mandibular partial denture	$50
D5730	Reline complete maxillary denture (chairside)	$25
D5731	Reline complete mandibular denture (chairside)	$25
D5740	Reline maxillary partial denture (chairside)	$25
D5741	Reline mandibular partial denture (chairside)	$25
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$60
D5811	Interim complete denture (mandibular)	$60
D5820	Interim partial denture (maxillary)	$40
D5821	Interim partial denture (mandibular)	$40
D5850	Tissue conditioning, maxillary	$10
D5851	Tissue conditioning, mandibular	$10

Prosthodontics (Fixed)

D6210	Pontic - cast high noble metal*	$115
D6211	Pontic - cast predominantly base metal	$115
D6212	Pontic - cast noble metal*	$115
D6214	Pontic - titanium	$115

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Code	Service	Member Co-payment
D6240	Pontic - porcelain fused to high noble metal*	$115
D6240	Pontic - porcelain fused to high noble metal (gold composite reinforced crown/Captek)	Co-payment + $300
D6241	Pontic - porcelain fused to predominantly base metal*	$115
D6242	Pontic - porcelain fused to noble metal*	$115
D6245	Pontic - porcelain/ceramic	$115
D6245	Pontic - porcelain/ceramic (Leucite-reinforced pressed crown/Empress)	Co-payment + $300
D6740	Crown - porcelain/ceramic	$225
D6740	Crown - porcelain/ceramic (Leucite-reinforced pressed crown/Empress)	Co-payment + $300
D6750	Crown - porcelain fused to high noble metal*	$115
D6750	Crown - porcelain fused to high noble metal (gold composite reinforced crown/Captek)	Co-payment + $300
D6751	Crown - porcelain fused to predominantly base metal*	$115
D6752	Crown - porcelain fused to noble metal*	$115
D6780	Crown - 3/4 cast high noble metal*	$115
D6781	Crown - 3/4 cast predominantly base metal	$115
D6782	Crown - 3/4 cast noble metal*	$115
D6790	Crown - full cast high noble metal*	$115
D6791	Crown - full cast predominantly base metal*	$115
D6792	Crown - full cast noble metal*	$115
D6794	Crown - titanium	$115
D6930	Recement fixed partial denture	$0
D6970	Cast post and core addition to fixed partial denture retainer*	$25
D6971	Cast post as part of fixed partial denture retainer*	$25
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$25
D6973	Core build up for retainer, including any pins*	$15
D6976	Each additional cast post - same tooth*	$25
D6977	Each additional prefabricated post - same tooth	$15

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Code	Service	Member Co-payment
Oral and Maxillofacial Surgery		
D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (extraction - each additional tooth)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal - exposed roots)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$20
D7220	Removal of impacted tooth - soft tissue	$35
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$95
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$130
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical access exposure of an unerupted tooth	$175
D7285	Biopsy of oral tissue - hard (bone, tooth)	$15
D7286	Biopsy of oral tissue - soft (all others)	$25
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$20
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$7
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$14
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$0
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$10
D7963	Frenuloplasty	$10

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Code	Service	Member Co-payment
D7971	Excision of pericoronal gingiva	$40

Orthodontics

D8050	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, primary dentition	$725
D8060	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, transitional dentition	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,950
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,950
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,250
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8999	Start-up fee (including exam, beginning records, x-rays, tracings, photos and models)	$250
D8999	Post-treatment records	$150
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	$35

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$125
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$60
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$125
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$60
D9310	Consultation - diagnostic service provided by dentist or physician (other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0

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Member Services (866) 249-2382

Code	Service	Member Co-payment
D9440	Office visit - after regularly scheduled hours	$20
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$100
D9942	Repair and/or reline of occlusal guard	$50
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$0
D9999	Record transfer - transfer of all materials with or without an x-ray	$15

Materials Upgrades for Non-Elective Dental Services (in addition to co-payment for service)

D2750	Porcelain on molar crowns	$75
D2999	Semi or precious metal for crowns	lab cost
D2740	Leucite-reinforced pressed crown/Empress	Co-payment + $300
D2750	Gold composite reinforced crown/Captek	Co-payment + $300
D5110	Comfort Flex Complete Upper Denture/acetyl resin homopolymer	Co-payment + $400
D5120	Comfort Flex Complete Lower Denture/acetyl resin homopolymer	Co-payment + $400
D5211	Comfort Flex Upper Partial Denture/acetyl resin homopolymer	Co-payment + $425
D5212	Comfort Flex Lower Partial Denture/acetyl resin homopolymer	Co-payment + $425

Cosmetic Dentistry Services (Elective Services)

D2330	Resin-based composite - one surface, anterior	$80
D2331	Resin-based composite - two surfaces, anterior	$95
D2332	Resin-based composite - three surfaces, anterior	$105
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$125
D2391	Resin-based composite - one surface, posterior	$85

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Code	Service	Member Co-payment
D2392	Resin-based composite - two surfaces, posterior	$100
D2393	Resin-based composite - three surfaces, posterior	$110
D2394	Resin-based composite - four or more surfaces, posterior	$130
D2740	Leucite-reinforced pressed crown/Empress	$700
D2750	Cosmetic crown - porcelain fused to predominately base/noble/high noble crown	$500
D2962	Labial veneer/porcelain laminate	$450
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer	$650
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer	$650
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer	$725
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer	$725
D9972	External bleaching - per arch	$125

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Exclusions and Limitations

Limitation of Benefits

Listed below are limitations on services covered under the plan.

1. Frequency - The frequency of certain benefits is limited. The Schedule of Benefits lists any limitations on frequency.
2. Specialty Care - Payment authorization is required for coverage of services by a participating Network Specialist.
3. Oral Surgery - The surgical removal of an impacted wisdom tooth is not covered if there is no pathology present, or if the removal is for orthodontic reasons.
4. Replacement of an existing crown (non-elective service) is covered only if it cannot be repaired and restored to natural function.
5. Replacement of an existing full or removable denture (non-elective service) is covered only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
6. Palliative treatment of dental pain will be considered for payment as a separate benefit only if no other services are rendered during visit.
7. Notwithstanding anything to the contrary that may be contained in the Evidence of Coverage, you will be reimbursed for all covered services which are deemed necessary emergency dental care.

Exclusions

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the dentist's Usual and Customary fee.

1. Services not listed on the Schedule of Benefits.
2. Services provided by a non-participating provider without prior approval, except in emergencies.
3. Services related to any injury or illness covered under Workers' Compensation, occupational disease or similar laws.
4. Services provided or paid through a federal or state government agency or authority, political subdivision or public program other than Medicaid.
5. Services relating to injuries which are intentionally self-inflicted.
6. Services required while serving in the armed forces of any country or international authority or relating to declared or undeclared act of war.
7. Cosmetic dentistry unless specifically listed as a covered benefit.
8. Prescription drugs.
9. Procedures, appliances or restorations if the purpose it to, a) change vertical dimension, or b) diagnose or treat abnormal conditions of the temporomandibular joint.
10. The completion of crown and bridge, dentures, root canal treatment, and orthodontics already in progress on the date the member becomes eligible under the plan.
11. Services associated with the placement or prosthodontic restoration of a dental implant.

12. Services considered to be unnecessary or experimental in nature.

13. Procedures or appliances for minor tooth guidance or to control harmful habits.

14. Hospitalization, including any associated incremental charges for dental services performed in a hospital.

15. Services to the extent the member is compensated for them under any group medical plan, no fault insurance policy or insured.

16. Crowns and bridges used solely for splinting.

17. Resin bonded retainers and associated pontics.

Orthodontic Benefit Limitations & Exclusions

1. Orthodontic benefits are available only at Participating Orthodontic offices.

2. If the member relocates to an area and is unable to receive treatment with the original Participating Orthodontist, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fee of the orthodontist where the treatment is completed.

3. Covered treatment cannot be transferred by the Member from one Participating Orthodontist to another Participating Orthodontist.

4. No benefit will be paid for an orthodontic treatment program that began before the Member enrolled in the Orthodontic Plan.

5. If the Member becomes ineligible during the course of treatment, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fees incurred for the entire remaining balance of treatment.

6. Orthognathic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy are excluded.

7. Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.

8. The following are not included in the orthodontic benefits and the orthodontist's Usual and Customary charges apply:

    - Lingual or clear brackets
    - Replacement of lost or broken appliances, bands brackets or orthodontic retainers.