Family Dental PPO Plan

Evidence of Coverage and Health Service Agreement

Individual and Family Plan

An independent member of the Blue Shield Association

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COVERED CALIFORNIA

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Blue Shield of California Individual and Family

Family Dental PPO 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 [Family Dental Customer Service] or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

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COVERED CALIFORNIA

Summary of Benefits

Individual and Family Dental Plan
DPPO Plan

Family Dental PPO

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: **DPPO Network**

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. 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. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Dentist[3]	When using a Non-Participating Dentist[4]
Calendar Year Pediatric Deductible	*Individual coverage*	$75	$75
	Family coverage	$75: individual $150: Family	$75: individual $150: Family
Calendar Year Adult Deductible	*Individual coverage*	$50	$50
	Family coverage	Not applicable	Not applicable

Calendar Year Out-of-Pocket Maximum[5]

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]	When using a Non-Participating Dentist[4]
Calendar Year Pediatric Out-of-Pocket Maximum	*Individual coverage*	$350	No maximum
	Family Coverage	$350: individual $700: Family	No maximum No maximum
Calendar Year Adult Out-of-Pocket Maximum	*Individual coverage*	No maximum	No maximum
	Family Coverage	Not applicable	Not applicable

Calendar Year Benefit Maximum[6]

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

		When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Pediatric Benefit Maximum		No maximum
Calendar Year Adult Benefit Maximum	*Individual coverage*	$1,500
	Family coverage	Not applicable

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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. The waiting period may be waived with proof of prior comparable coverage.

Pediatric waiting period	No waiting period
Adult waiting period	6 months for major services

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[7,8,9]

	Your payment			
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**	**When using a Non-Participating Dentist[4]**	**CYD[2] applies**
Office visit	$0		$0	
Diagnostic and preventive services				
Oral exam	$0		10%	
Preventive – cleaning	$0		10%	
Preventive – x-ray	$0		10%	
Sealants per tooth	$0		10%	
Topical fluoride application	$0		10%	
Space maintainers – fixed	$0		10%	
Basic services				
Restorative procedures	20%	✔	30%	✔
Periodontal maintenance	20%	✔	30%	✔
Adjunctive general services	20%	✔	30%	✔
Major services				
Oral Surgery	50%	✔	50%	✔
Endodontics	50%	✔	50%	✔
Periodontics (other than maintenance)	50%	✔	50%	✔
Crowns and casts	50%	✔	50%	✔
Prosthodontics	50%	✔	50%	✔
Orthodontics (Medically Necessary)	50%	✔	50%	✔

Adult Benefits[7,8,9]

	Your payment			
Adult Benefits are available for Members age 19 and older.	**When using a Participating Dentist[3]**	**CYD[2] applies**	**When using a Non-Participating Dentist[4]**	**CYD[2] applies**
Office visit	$0		$0	
Diagnostic and preventive services				
Oral exam	$0		10%	
Preventive – cleaning	$0		10%	
Preventive – x-ray	$0		10%	
Sealants per tooth	$0		10%	
Topical fluoride application	$0		10%	

Adult Benefits[7,8,9]

Adult Benefits are available for Members age 19 and older.	Your payment: When using a Participating Dentist[3]	CYD[2] applies	When using a Non-Participating Dentist[4]	CYD[2] applies
Space maintainers – fixed	$0		10%	
Basic services				
Restorative procedures	20%	✔	30%	✔
Periodontal maintenance	20%	✔	30%	✔
Adjunctive general services	20%	✔	30%	✔
Major services				
Oral Surgery	50%	✔	50%	✔
Endodontics	50%	✔	50%	✔
Periodontics (other than maintenance)	50%	✔	50%	✔
Crowns and casts	50%	✔	50%	✔
Prosthodontics	50%	✔	50%	✔
Orthodontics (Medically Necessary)	Not covered		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.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year Deductible. Some Covered Services are paid by Blue Shield before you meet any Calendar Year Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has separate Deductibles for:

- Pediatric Deductible and Adult Deductible
- Participating Dentist Deductible and Non-Participating Dentist Deductible

Individual Pediatric Deductible. Each Pediatric Member is responsible for the individual Deductible unless the family Deductible has been met, if applicable.

Individual Adult Deductible. Each Adult Member is responsible for an individual Deductible.

Family Pediatric Deductible. 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 Deductible and the family in-network Deductible, if applicable. Cost sharing payments made by each Pediatric Member for out-of-network Covered Services contribute to both the individual out-of-network Deductible and the family out-of-network Deductible, if applicable.

Once the individual Deductible or the family Deductible (if applicable) is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

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.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum or any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 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.

Non-Participating Dentist OOPM. Cost sharing payments made by Members for out-of-network Covered Services do not accumulate to the OOPM.

6 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

Notes

All Covered Services count towards the Calendar Year Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

7 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.

8 Dental Care Services:

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

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 only if the Member remains enrolled in the Plan. All procedures performed in connection with Orthodontic treatment are payable as Orthodontic Covered Services.

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.

This plan is compliant 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.

9 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than $250 is started, you should obtain prior authorization of Benefits, except in an emergency.

Plans may be modified to ensure compliance with State and Federal requirements.

Introduction to the Family Dental PPO Plan

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

Your interest in Blue Shield of California Family Dental PPO Plan is truly appreciated. Blue Shield of California (Blue Shield) has been serving Californians for over 60 years, and we look forward to serving your dental care needs.

Blue Shield's dental plans are administered by a Dental Plan Administrator (DPA), which is an entity that contracts with Blue Shield of California 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: [Family Dental Customer Service].

Before Obtaining Dental Services

You are responsible for assuring that the Dentist you choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area, can be obtained by contacting a Dental Plan Administrator at [Family Dental Customer Service]. You may also access a list of Participating Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. You are also responsible for following the Precertification of Dental Benefits Program which includes obtaining or assuring that the Dentist obtains precertification of Benefits.

NOTE: A Dental Plan Administrator will respond to all requests for precertification and prior Authorization within 5 business days from receipt of the request. For urgent services in situations in which 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 will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of Benefits. However, by following the Precertification process both you and the Dentist will know in advance which services are covered and the Benefits that are payable.

Participating Dentists

The Blue Shield of California Family Dental PPO Plan is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment or Coinsurance, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

If you go to a Non-Participating Dentist, you will be reimbursed up to a pre-determined maximum amount, for Covered Services. Your reimbursement may be substantially less than the billed amount. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by Non-Participating Dentists. It is therefore to your advantage to obtain dental services from Participating Dentists.

Participating Dentists submit claims for payment after their services have been rendered. These payments go directly to the Participating Dentist. You or your Non-Participating Dentists submit claims for reimbursement after services have been rendered. If you receive services from Non-Participating Dentists, you have the option of having payments sent directly to the Non-Participating Dentist or sent directly to you. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

The Member should contact Customer Services if the Member needs assistance locating a provider in the Member's Service Area. The plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Dentist is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Dentist level.

You may also access a list of Participating Dentists through Blue Shield's Internet site located at http://www.blueshieldca.com.

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
Telephone Inquiries	**Access to Care**

Access to a dental professional to evaluate the Member's dental concerns and symptoms	Within 30 minutes, 24 hours/day 7 days/week

Note: For availability of interpreter services at the time of the Member's appointment, contact Customer Service at the number shown in the "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.

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 PPO 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 Dental Plan Administrator's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Participating Dentist in the same geographic area.

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.

<u>Eligibility for this plan</u>

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.

<u>Enrollment and effective dates of coverage</u>

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 the application or request for special enrollment by the 15th of the month, the effective date of coverage will be the 1st of the next month. If the Subscriber submits the application or request after the 15th of the month, the effective date of coverage will be the 1st of the second month after the submission.

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

When Blue Shield or Covered California cancels, does not renew, or rescinds coverage	
Reason	***Date coverage ends***
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 pre-paid Premiums. Renewal is subject to Blue Shield of California's right to amend this Agreement. Any change in Premiums or Benefits, including but not limited to Covered Services, Deductible, Coinsurance or Copayment, and annual maximum amounts, 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.

Precertification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, you should obtain precertification of Benefits. Your Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to a Dental Plan Administrator. A Dental Plan Administrator will review the dental treatment plan to determine the Benefits payable under the Plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, your claim form should be submitted to a Dental Plan Administrator for payment determination. A Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

The dental Plan provides Benefits for Covered Services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this Plan will in most cases provide Benefits based on the most cost-effective procedure. The Benefits provided under this Plan are based on these considerations but you and your Dentist make the final decision regarding treatment.

Failure to obtain precertification of Benefits may result in a denial of Benefits. If the precertification process is not followed, a Dental Plan Administrator will still determine payment by taking into account alternative procedures; services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the precertification process both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material which meets professionally recognized standards of quality dental care and is the most cost effective as determined by a Dental Plan Administrator. If you and your Dentist decide on a more costly procedure, service or material than a Dental Plan Administrator determined is payable under the Plan, then Benefits will be applied to the selected treatment plan up to the benefit maximum for the most cost effective alternative. You will be responsible for any charges in excess of the benefit amount. A Dental Plan Administrator reserves the right to use the services of dental consultants in the precertification review.

Example:

1. If a crown is placed on a tooth which can be restored by a filling, Benefits will be based on the filling;
2. If a semi-precision or precision partial denture is inserted, Benefits may be based on a conventional clasp partial denture;
3. If a bridge is placed and the patient has multiple unrestored missing teeth, Benefits will be based on a partial denture.

Payment and Subscriber Coinsurance or Copayment Responsibilities

Participating Dentists

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE PROVIDED.

When you receive covered dental services from a Participating Dentist, you will be responsible for a fixed Coinsurance or Copayment as outlined in the section entitled Summary of Benefits. Participating Dentists will file claims on your behalf.

Services rendered for diagnostic and preventive care will be paid at 100%, subject to certain limitations as specified in the section entitled “Covered Services and Supplies”.

Participating Dentists will be paid directly by the Plan, and have agreed to accept a Dental Plan Administrator’s payment, plus your payment of any applicable Deductible, Coinsurance or Copayment, as payment in full for Covered Services.

If the covered Member recovers from a third party the reasonable value of Covered Services rendered by a Participating Dentist, the Participating Dentist who rendered these services is not required to accept the fees paid by a contracted Dental Plan Administrator as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by a Dental Plan Administrator and the amount collected by the covered Member for these services.

Non-Participating Dentists

When you receive Covered Services from a Non-Participating Dentist, you will be reimbursed up to a specified maximum amount as outlined in the section entitled “Summary of Benefits”. You will be responsible for the remainder of the Dentist’s billed charges. You should discuss this beforehand with your Dentist if he is not a Participating Dentist. Any difference between a Dental Plan Administrator’s or Blue Shield of California’s payment and the Non-Participating Dentist's charges are your responsibility. Members are expected to follow the billing procedures of the dental office.

If you receive Covered Services from a Non-Participating Dentist, either you or your provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

[Family Dental Customer Service]

Claims for Covered Services rendered by Non-Participating Dentists, should be sent to:

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

Calendar Year Deductible

The Calendar Year Deductible is the amount the Member must pay out of pocket before Benefits will be provided for Covered Services. This Deductible applies separately to each covered Member each Calendar Year.

For Plans with a Calendar Year Deductible, the Deductible applies to all Covered Services and supplies furnished by Plan and Non-Participating Dentists, except as specified in the Summary of Benefits which is attached to and made a part of this EOC. It is the amount which you must pay out of pocket for charges that would otherwise be payable for Dental Care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the Deductible. This per Member Deductible applies separately to each covered Member each Calendar Year, except that no more than the Family Deductible amount is required of a Family of two or more Pediatric Members in a Calendar Year. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan.

Please see the Summary of Benefits for additional information.

Reimbursement Provisions

Procedure for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from the contracted Dental Plan Administrator or at blueshieldca.com. Have your Dentist complete the form and mail it to the contracted Dental Plan Administrator service center shown on the last page of this booklet.

A contracted Dental Plan Administrator will provide payment in accordance with the provisions of this Agreement. You will receive an explanation of Benefits after the claim has been processed.

All claims for reimbursement must be submitted to a contracted Dental Plan Administrator within one (1) year after the month in which the service is rendered. A contracted Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Calendar Year Maximum

The Calendar Year maximum for Covered Services and supplies provided by Plan and Non-Participating Dentists is specified on the Summary of Benefits.

Waiting Period

For Adults, there is a 6-month waiting period for Major Services. A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services. The waiting period will be waived with proof of prior comparable coverage. If you had prior comprehensive coverage, please contact Member Services at [Family Dental Customer Service] for more information about obtaining a waiver.

There is no waiting period for Pediatric dental Benefits.

Adult and Pediatric Principal Benefits & Coverages

The Benefits of the Plan are listed in the Summary of Benefits and the Dental Schedule and Limitations Table which is inserted as part of this booklet. Blue Shield payments for these services, if applicable, are also listed in the Summary of Benefits.

IMPORTANT INFORMATION

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the contract, to any conditions or limitations set forth in the Dental Schedule and Limitations Table and to the limitations and exclusions listed in this booklet.

Benefits of the Plan are provided for services customarily performed by Dentists for treatment of teeth, jaws and their dependent tissues.

These Benefits are subject to the general limitations and exclusions of the Plan. Payments are subject to the dental Benefit Deductible and to the Coinsurance or Copayment amounts indicated in the section entitled “Summary of Benefits”.

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.

Adult and Pediatric Diagnostic and Preventive Services

Diagnostic and preventive services provided by Participating Dentists will be covered at 100%, subject to the limitations in the General Limitations section and on the Dental Schedule and Limitations Table.

Adult Basic Services

Endodontics, Oral Surgery, Periodontics and Restorative Services

Refer to the section entitled “Summary of Benefits” for Coinsurance or Copayments and maximum reimbursement amounts.

Anesthesia — General, intravenous, or inhalation sedation is only a covered Benefit when provided in conjunction with a covered oral surgical procedure. See General Limitations and Exclusions section for more details.

Endodontics — Pulp capping; therapeutic pulpotomy — deciduous teeth only (in addition to restoration); vital pulpotomy — deciduous teeth only; apexification; root canals on permanent teeth only, including pulpotomy or other Palliative Treatment and necessary x-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage).

Oral Surgery — Extractions; removal of impacted teeth, radical excision of small (to 1.25 cm) non-malignant lesions;

other surgical procedures; includes local anesthesia and routine pre and postoperative care.

Palliative — Emergency treatment for relief of pain.

Periodontics — Emergency treatment including but not limited to, periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits; Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material. Onlays, crowns (other than stainless steel); veneers and other laboratory produced restorations and bridges are excluded.

Adult Major Services

Refer to the section entitled Summary of Benefits for Coinsurance or Copayments and maximum reimbursement amounts.

Implants — When a Benefit of your Plan, single tooth Implant is offered for initial replacement of any missing single tooth except second and third molars and lower anterior teeth. Failed Implant, second and third molar and lower anterior tooth replacement is not included. Benefits include the surgical Implant placement, bone grafting to the site (if required), abutment that screws into the Implant body (if one is utilized) and the prosthetic crown that is supported by the surgical Implant. Benefits are provided for the maintenance, repair and removal of the Implant.

Prosthetics — Bridges, dentures, partials and relining or re-basing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stayplate, and special tissue conditioning per denture. No replacement of complete or partial dentures, Implants, fixed bridgework or crowns previously covered by the Plan due to loss or theft within sixty (60) months after initial or supplemental placement. This also applies to the damage of any prostheses that is not directly related to faulty lab work. “Prostheses” include retainers, habit appliances and any fixed or removable interceptive Orthodontic appliances as well as fixed and removable bridgework.

No replacement of dentures (complete or partial), crowns or fixed bridgework due to provider error. The provider is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of, the patient, that patient is financially liable for replacement of the Prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The Plan will pay for a replacement in this instance after the sixty (60) months waiting period from initial placement has elapsed.

Denture relines (either complete or partial conventional dentures) within six (6) months after insertion of the Prosthesis. This service is covered once every twelve months following initial insertion or reline. In the case of immediate full or partial dentures, the final reline must be performed no sooner than eight weeks after tooth extractions and denture insertion. Chair-side tissue conditioners can be used for temporary relief of discomfort and/or to increase retention and be considered Palliative Treatment. Relines for immediate full and partial dentures will not be covered within two (2) weeks of tooth extraction and Prosthesis insertion. One reline for each Prosthesis is included in the immediate denture fee between two (2) and six (6) months following insertion.

Cast Restorations — Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (onlays and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). There is no coverage for replacement of an existing crown, onlay, or other cast restoration which is less than five (5) years old. Repair or re-cementing of onlays and crowns, is covered for six (6) months after installation.

Pediatric Orthodontics — Dental Care Services specifically related to necessary services for the treatment for malocclusion and the proper alignment of teeth are covered, if rendered by a Plan Dental Provider. Orthodontics is not a covered Benefit for Adult Members. Orthodontics is covered for Pediatric Members only as described in the Summary of Benefits and on the Dental Schedule Limitations Table.

Telehealth Services

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

Important Information

Services are Benefits of the Plan when provided by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the benefit descriptions below, and to the limitations and exclusions listed in this booklet.

Benefits of the Plan are provided for services customarily performed by licensed Dentists for treatment of teeth, jaws and their dependent tissues.

Payments are based on the Allowable Amount as defined, and are subject to the dental Benefit Deductible, the indicated Coinsurance percentages, and all Benefit maximums as specified in the Summary of Benefits.

Member Maximum Lifetime Benefits

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

General Exclusions and Limitations

Adult and Pediatric General Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;
2. 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;
3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
4. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
5. Cosmetic dental care;
6. Hospital charges of any kind;
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. Treatment for which payment is made by any governmental agency, including any foreign government;
9. Charges for second opinions, unless previously authorized by the DPA;
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. Services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services or is not operating within the scope of such license or certification, except as specifically stated herein;
12. Any procedure not performed in a dental office setting; except for general anesthesia when Medically Necessary;
13. General anesthesia including intravenous and inhalation sedation, except when Medically Necessary.

    General anesthesia is considered Medically Necessary when its use is:

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

    Patient apprehension or patient anxiety will not constitute Medical Necessity.

    A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Medical Necessity;
14. Loss or theft of dentures or bridgework;
15. Services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Dental Provider and authorized by the Plan, or when required in a covered emergency;
16. Any dental services received or costs that were incurred in connection with any dental procedures started prior to Member's effective date of coverage. For the purpose of this exclusion, the date on which a procedure shall be considered to have started 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;
17. Any dental services received subsequent to the time the Member's coverage ends;
18. 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;
19. 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;
20. All prescription and non-prescription drugs;
21. The cost of precious metals used in any form of dental Benefits;

22. 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; and

23. House calls for dental services.

Adult General Exclusions

Unless exceptions to the following Adult general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, 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;
2. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, Orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
3. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
4. 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;
5. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;
6. Myofunctional therapy; biofeedback procedures; athletic mouth-guards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures;
7. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw; charges for services in connection with orthodontia;
8. Charges for services in connection with orthodontia;
9. Alloplastic bone grafting materials;
10. Bone grafting done for socket preservation after tooth extraction (unless your Plan provides special Implant Benefits. Please see the Summary of Benefits to determine if you have Implant Benefits.);
11. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
12. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
13. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
14. Services for which the Member is not legally obligated to pay, or for services for which no charge is made;
15. Treatment as a result of Accidental Injury including setting of fractures or dislocation; Treatment for which payment is made by any governmental agency, including any foreign government;
16. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
17. Charges for onlays or crowns installed as multiple abutments;
18. Any inlay restoration;
19. Charges for dental appointments which are not kept, except as specified under the Summary of Benefits;
20. Charges for services incident to any intentionally self-inflicted injury;
21. Removal of 3rd molar (wisdom) teeth other than for Medical Necessity. Medical Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not Medically Necessary;
22. 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;
23. For services provided by an individual or entity that is not licensed or certified by the state to provide Dental Care Services, or is not operating within the scope of such license or certification, except as specifically stated herein;
24. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed; and

25. Any and all Implant services that have not received prior authorization and approval by a contracted Dental Plan Administrator if your Plan provides special Implant Benefits. 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 Limitations Table, will be subject to limitations as set forth below:

1. Oral Surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening;
2. 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 (1) 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;
3. General or IV sedation is not a covered Benefit for dental phobic reasons;
4. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
5. For mucogingival surgeries, one (1) site is equal to two (2) consecutive teeth or bonded spaces;
6. 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; and
7. You must be twenty-one (21) years or older to be eligible for dental Implant benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth and/or non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If there are more than three (3) teeth missing and/or more than three non-restorable and/or unrestored teeth in a quadrant in the same dental arch or in the maxillary anterior area, the Member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit.

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 Participating Dentist or other Plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity.

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 Plan will pay Benefits based upon the less costly service.

Exception for Other Coverage

A Participating Dentist may seek reimbursement from other third party payors 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 of California 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 paid by Blue Shield of California or a contracted Dental Plan Administrator on a fee-for-service basis 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 thirty 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 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.

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part of 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.

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.

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."

The determination of whether the situation required Emergency Services will be made retrospectively by a contracted Dental Plan Administrator based upon an objective review that is consistent with professionally recognized standards of care.

If a Member receives Emergency Services outside of California, you will be reimbursed up to the maximum amount listed under the Out-of-Network column in section entitled "Summary of Benefits". The Member will be responsible for the remainder of the Dentist's billed charges. Whenever possible, the Member should ask the Dentist to bill the Plan directly.

Payment or reimbursement of Emergency Services provided to a Member will be made after a Dental Plan Administrator receives documentation of the charges incurred and upon approval by a 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 of California. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

Premiums

Monthly Premiums are stated in the Appendix. Blue Shield of California offers a variety of options and methods by which you may pay your Premiums.

Please call Customer Service at [Family Dental Customer Service] 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 60514
City of Industry, CA 91716

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.

General Provisions

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part of 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.

Claims and Services Review

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

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of Benefits in excess of the Benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (Deductibles, Copayment amounts, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Liability of Subscribers in the Event of Non-Payment by Blue Shield of California

In accordance with Blue Shield of California's established policies, and by statute, every contract between a Dental Plan Administrator and its Participating Dentists stipulates that the Subscriber shall not be responsible to the Participating Dentist for compensation for any services to the extent that they are provided in the Subscriber's medical policy. When services are provided by a Participating Dentist, the Subscriber is responsible for any applicable Deductible, Coinsurance or Copayment amounts, and charges in excess of Benefit maximums.

If services are provided by a Non-Participating Dentist, the Subscriber is responsible for any amount Blue Shield of California does not pay.

When a Benefit specifies a maximum allowance and the Plan's maximum has been reached, the Subscriber is responsible for any charges above the Benefit maximum amounts.

Entire Agreement: Changes

This Agreement, including the appendices, constituted the entire Agreement between parties. Any statement made by a Member shall, in the absence of fraud, be deemed a representation and not a warranty. No changes in this Agreement shall be valid unless approved by a corporate officer of Blue Shield of California and a written endorsement 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, Coinsurance or Copayment, or Maximum per Member and family 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 change.

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 Reconcili-

ation 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.
3. Loss of Medi-Cal coverage for pregnancy-related services or loss of access to CHIP unborn child coverage due to the birth of the child. Additional 60-day period before Triggering Event applies.
4. Loss of Medicaid medically needy coverage (only once per calendar year). Additional 60-day period before Triggering Event applies.
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 Na-

tional 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.

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 three (3) years after the time written proof of claim is required to be furnished.

Choice of Providers

Under this Plan, you have a free choice of any licensed Dentist including such providers outside of California.

Facilities (Participating Dentists)

The names of Participating Dentists in your area may be obtained by contacting a Dental Plan Administrator at [Family Dental Customer Service].

Notices

Any notice required by this Agreement may be delivered by United States mail, postage pre-paid. Notice to the Subscriber may be mailed to the address appearing on the records of Blue Shield of California and notice to Blue Shield of California may be mailed to:

Blue Shield of California
601 12th Street
Oakland, CA 94607

Independent Contractors

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

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are appendices pertaining to Premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled “Duration of the Agreement”. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Identification Cards

Identification cards will be issued by Blue Shield of California to all Subscribers.

Possession of a Blue Shield of California identification card confers no right to services or other Benefits of this Agreement. To be entitled to services, the Member must be a Subscriber who has maintained enrollment under the terms of this Agreement.

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 upon Blue Shield of California must be served upon a corporate officer of Blue Shield of California.

Non-Assignability

Coverage or any Benefits of the Blue Shield of California dental plans are not assignable without the written consent of Blue Shield of California.

The coverage and Benefits of the Blue Shield of California dental plan are assignable to Participating Dentists and Non-Participating Dentists.

Utilization Review

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield of California has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the document describing this Utilization Review process, call the Customer Service Department at 1-888-256-3650.

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 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.

Dental Customer Services

Questions about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced should be directed to your Dental Customer Service at the phone number or address which appear below:

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

Dental Customer Service can answer many questions over the telephone.

If the grievance involves a Non-Participating Dentist, the Subscriber should contact the appropriate Blue Shield Customer Service Department shown on the last page of this Evidence of Coverage and Health Service Agreement.

Note: A Dental Plan Administrator has established a procedure for our Subscribers to request an expedited decision. A Subscriber, physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. A Dental Plan Administrator shall make a decision and notify the Subscriber and physician as soon as possible to accommodate the Member's condition not to exceed 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 the Dental Customer Service Department at the number listed above.

Grievance Process

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Subscribers' grievances.

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Dental Member Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Member Service 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 Service 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 Service Department. If the Member wishes, the Dental Member Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Dental Plan

Administrator at the address provided below. The Member may also submit the grievance to the Dental Member Service Department online by visiting http://www.blueshieldca.com.

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

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

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

Department of Managed Health Care Review

The California Department of Managed Health Care (the Department) 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 [Family Dental Customer Service] 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 **(http://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 of California will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield of California'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 Customer Service Department at the number listed in the Customer Service Section 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 of California 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

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@BlueShieldca.com

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 health 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 of California is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield of California. 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: 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 ten business days after the minutes have been approved.

Definitions

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

Accidental Injury – definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

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 – the amount a Participating Dentist agrees to accept as payment from a Dental Plan Administrator or the billed amount for Non-Participating Dentists.

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.

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

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) – Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is 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 (Plan Provider) – 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;

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 – Member 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 PPO 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 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.

Steve Shearer
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
[Family Dental Customer Service]

Blue Shield of California
[Family Dental Customer Service]

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	Adult Limitation
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.	once every 6 months or after 6 months have elapsed following comprehensive oral evaluation (D0150).
D0140	Limited oral evaluation – problem focused	once per Member per provider.	once within a 1-month period for the same dental problem.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		Not a Benefit.
D0150	Comprehensive oral evaluation – new or established patient	once per Member per provider for the initial evaluation.	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.
D0160	Detailed and extensive oral evaluation – problem focused, by report	once per Member per provider.	once within a 1-month period for the same dental problem.
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.	once within a 1-month period for the same dental problem.
D0171	Re-evaluation – post-operative office visit		
D0180	Comprehensive periodontal evaluation – new or established patient		once every 24-months.
D0190	Screening of a patient	not a Benefit.	
D0191	Assessment of a patient	not a Benefit.	
D0210	Intraoral - complete series of radiographic images	once per provider every 36 months.	once every 3 years.
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.	one per day.
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	up to 3 per day.

Code	Description	Pediatric Limitation	Adult Limitation
		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.	
D0240	Intraoral - occlusal radiographic image	up to a maximum of two in a 6 month period per provider.	up to 2 per visit.
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.	one per year.
D0251	Extra-oral posterior dental radiographic image	up to a maximum of 4 on the same date of service.	not a Benefit.
D0270	Bitewing - single radiographic image	once per date of service. Not a Benefit for a totally edentulous area.	two per 6-month period. Total number of bitewings should not be more than four (4) in a 1- year period.
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.	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.
D0273	Bitewings - 3 radiographic images		one per year. Total number of bitewings should not be more than four (4) in a 1- year period.
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.	one per year. Total number of bitewings should not be more than four (4) in a 1- year period.
D0277	Vertical bitewings - 7 to 8 radiographic images		not a Benefit.
D0310	Sialography		not a Benefit.
D0320	Temporomandibular joint arthrogram, including injection	limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.	not a Benefit.
D0322	Tomographic survey	up to twice in a 12 month period per provider.	not a Benefit.
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).	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.
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12 month period per provider.	not a Benefit.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	up to a maximum of 4 per date of service.	not a Benefit.
D0351	3D photographic image		once per year when medically necessary to image the face or mouth for orthodontic treatment. Not a benefit for endodontic, restorative dentistry, periodontic or oral surgery.
D0419	Assessment of salivary flow by measurement	not a Benefit.	not a Benefit.
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.	Once every 12-month period for Adults 21 years old and greater.

Code	Description	Pediatric Limitation	Adult Limitation
D0460	Pulp vitality tests		not billable as a separate procedure & included as part of the diagnosis.
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.	
D0502	Other oral pathology procedures, by report	must be provided by a certified oral pathologist.	not a Benefit.
D0601	Caries risk assessment and documentation, with a finding of low risk		once per year when done in conjunction with D0120, D0150.
D0602	Caries risk assessment and documentation, with a finding of moderate risk		once per year when done in conjunction with D0120, D0150.
D0603	Caries risk assessment and documentation, with a finding of high risk		once per year when done in conjunction with D0120, D0150.
D0701	Panoramic radiographic image – image capture only		not a Benefit.
D0702	2-D cephalometric radiographic image – image capture only		not a Benefit.
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only		not a Benefit.
D0704	3-D photographic image – image capture only		not a Benefit.
D0705	Extra-oral posterior dental radiographic image – image capture only		not a Benefit.
D0706	Intraoral – occlusal radiographic image – image capture only		not a Benefit.
D0707	Intraoral – periapical radiographic image – image capture only		not a Benefit.
D0708	Intraoral – bitewing radiographic image – image capture only		not a Benefit.
D0709	Intraoral – complete series of radiographic images – image capture only		not a Benefit.
D0999	Unspecified diagnostic procedure, by report		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.
Preventive Procedures (D1000-D1999)			
D1110	Prophylaxis - Adult		once in a 6 month period.
D1120	Prophylaxis – child	once in a 6 month period.	not a Benefit.
D1206	Topical application of fluoride varnish	once in a 6 month period.	3 in a 12-month period for a Member with moderate to high risk caries.
D1208	Topical application of fluoride – excluding varnish	once in a 6 month period.	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D1310	Nutritional counseling for control of dental disease		
D1320	Tobacco counseling for the control and prevention of oral disease		
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use		
D1330	Oral hygiene instructions		not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
D1353	Sealant repair – per tooth		not a Benefit.
D1354	Interim caries arresting medicament application - per tooth		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.
D1355	Caries preventive medicament application – per tooth		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.
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.	not a Benefit.
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.	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
D1556	Removal of fixed unilateral space maintainer - per quadrant	not a Benefit to the original provider who placed the space maintainer.	not a Benefit.
D1557	Removal of fixed bilateral space maintainer - maxillary	not a Benefit to the original provider who placed the space maintainer.	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D1558	Removal of fixed bilateral space maintainer - mandibular	not a Benefit to the original provider who placed the space maintainer.	not a Benefit.
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant		not a Benefit.
Restorative Procedures (D2000-D2999)			
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.	once per 12-month period per tooth. .
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	once per 12-month period per tooth.
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.	not a Benefit.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
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.	once per 12-month period per tooth.
D2542	Onlay - metallic – 2 surfaces	not a Benefit.	one per five years per surface combination. must include one or more of the following surfaces: B, L (cusp replacement).
D2543	Onlay - metallic – 3 surfaces	not a Benefit.	one per five years per surface combination. must include one or more of the following surfaces: B, L (cusp replacement).
D2544	Onlay - metallic – 4 or more surfaces	not a Benefit.	one per five years per surface combination.

Code	Description	Pediatric Limitation	Adult Limitation
			must include one or more of the following surfaces: B, L (cusp replacement).
D2642	Onlay - porcelain/ceramic – 2 surfaces	not a Benefit.	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.
D2643	Onlay - porcelain/ceramic – 3 surfaces	not a Benefit.	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.
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	not a Benefit.	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.
D2662	Onlay - resin-based composite – 2 surfaces	not a Benefit.	not a Benefit.
D2663	Onlay - resin-based composite – 3 surfaces	not a Benefit.	not a Benefit.
D2664	Onlay - resin-based composite – 4 or more surfaces	not a Benefit.	not a Benefit.
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.	one crown per tooth per five years.
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.	one crown per tooth per five years.
D2720	Crown - resin with high noble metal	not a Benefit.	not a Benefit.
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	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
		an abutment for an existing removable partial denture with cast clasps or rests.	
D2722	Crown - resin with noble metal	not a Benefit.	not a Benefit.
D2740	Crown – porcelain/ceramic substrate	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.	one crown per tooth per five years.
D2750	Crown - porcelain fused to high noble metal	not a Benefit.	one crown per tooth per five years.
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.	one crown per tooth per five years.
D2752	Crown - porcelain fused to noble metal	not a Benefit.	one crown per tooth per five years.
D2753	Crown - porcelain fused to titanium and titanium alloys	not a Benefit.	one crown per tooth per five years.
D2780	Crown – 3/4 cast high noble metal	not a Benefit.	one crown per tooth per five years.
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.	one crown per tooth per five years.
D2782	Crown – 3/4 cast noble metal	not a Benefit.	one crown per tooth per five years.
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.	one crown per tooth per five years.
D2790	Crown – full cast high noble metal	not a Benefit.	one crown per tooth per five years.
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:	one crown per tooth per five years.

Code	Description	Pediatric Limitation	Adult Limitation
		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.	
D2792	Crown – full cast noble metal	not a Benefit.	one crown per tooth per five years.
D2794	Crown – titanium and titanium alloys	not a Benefit.	one crown per tooth per five years.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider.	once per 6-month period.
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		once per 5 years per tooth.
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.	once per 6-month period.
D2921	Reattachment of tooth fragment, incisal edge or cusp		anterior upper tooth only; once per 24-month period.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	once in a 12 month period.	not a Benefit.
D2929	Prefabricated porcelain/ceramic crown - primary tooth	once in a 12 month period.	not a Benefit.
D2930	Prefabricated stainless steel crown – primary tooth	once in a 12 month period.	not a Benefit.
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.	once per 3 years per tooth. Tooth numbers 1-5, 12-20, and 28-32.
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.	not a Benefit.
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.	not a Benefit.
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.	one per 6-month period per tooth.
D2941	Interim therapeutic restoration – primary dentition		not a Benefit.
D2949	Restorative foundation for an indirect restoration		not a Benefit.
D2950	Core buildup, including any pins when required		once per five years per tooth for tooth numbers 1-32.

Code	Description	Pediatric Limitation	Adult Limitation
			Not a benefit to restore undercuts in the preparation or "cavities" that develop as the result of removing pathology (decay) from the prepared tooth.
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.	once per restoration, regardless of number of pins used for tooth numbers 1-32.
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.	once per five years per tooth for tooth numbers 1-32.
D2953	Each additional indirectly fabricated post – same tooth		once per five years per tooth for tooth numbers 1-32.
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.	once per five years per tooth for tooth numbers 1-32.
D2955	Post removal		not a Benefit.
D2957	Each additional prefabricated post - same tooth		once per five years per tooth for tooth numbers 1-32.
D2971	Additional procedures to construct new crown under existing partial denture framework		not a Benefit.
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.	once per 6-month period per tooth.
D2999	Unspecified restorative procedure, by report		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.
Endodontics Procedures (D3000-D3999)			
D3110	Pulp cap – direct (excluding final restoration)		once per tooth per lifetime.
D3120	Pulp cap – indirect (excluding final restoration)		not payable as a separate benefit. considered part of final restoration.
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.	once per tooth per lifetime.
D3221	Pulpal debridement, primary and permanent teeth	once per permanent tooth; over-retained primary teeth with no permanent successor.	once per tooth per lifetime.

Code	Description	Pediatric Limitation	Adult Limitation
		Not a Benefit on the same date of service with any additional services, same tooth.	
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.	not a Benefit.
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.	not a Benefit.
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.	not a Benefit.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	once per tooth per lifetime for tooth numbers 6-11, 22-27.
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	once per tooth per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, and 29.
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.	once per tooth per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31.
D3331	Treatment of root canal obstruction; non-surgical access		not a Benefit.
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	not a Benefit.	not a Benefit.
D3333	Internal root repair of perforation defects		once per tooth per lifetime for teeth 1-32 only.
D3346	Retreatment of previous root canal therapy – anterior	once per tooth after more than 12 months has elapsed from initial treatment.	once per tooth per lifetime for tooth numbers 6-11, 22-27.
D3347	Retreatment of previous root canal therapy – bicuspid	once per tooth after more than 12 months has elapsed from initial treatment.	once per tooth per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, and 29.
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.	once per tooth per lifetime for tooth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32.

Code	Description	Pediatric Limitation	Adult Limitation
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.	once per tooth per lifetime for tooth numbers 2-15, 18-31 only.
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.	once per 3-month period for tooth numbers 2-15, 18-31 only.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	not a Benefit.	once per tooth per lifetime for tooth numbers 2-15, 18-31.
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.	once per root per lifetime for tooth numbers 6-11, 22-27. not a Benefit during the first 6-8 weeks after RCT (D3310).
D3421	Apicoectomy – bicuspid (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.	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.
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.	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.

Code	Description	Pediatric Limitation	Adult Limitation
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.	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.
D3430	Retrograde filling – per root		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.
D3450	Root amputation - per root	not a Benefit.	once per root per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31 only.
D3471	Surgical repair of root resorption – anterior		once per root per lifetime for only tooth numbers 6-11, 22-27.
D3472	Surgical repair of root resorption premolar		once per root per lifetime for tooth numbers 4, 5, 12, 13, 20, 21, 28, 29.
D3473	Surgical repair of root resorption – molar		once per root per lifetime for only tooth numbers 3, 4, 14, 15, 18, 19, 30, 31.
D3910	Surgical procedure for isolation of tooth with rubber dam		not a Benefit.
D3920	Hemisection (including any root removal), not including root canal therapy	not a Benefit.	Once per tooth, per lifetime for tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31 only.
D3950	Canal preparation and fitting of preformed dowel or post	not a Benefit.	Not a Benefit.
D3999	Unspecified endodontic procedure, by report		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.
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.	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.
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.	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.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Once per quadrant per 24- month period.

Code	Description	Pediatric Limitation	Adult Limitation
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Once per quadrant per 24- month period.
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.	Once per tooth per 5 years.
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.	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).
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.	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).
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	not a Benefit.	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).
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	not a Benefit.	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).
D4265	Biologic materials to aid in soft and osseous tissue regeneration	for Members age 13 or older.	Not a Benefit.
D4266	Guided tissue regeneration – resorbable barrier, per site	not a Benefit.	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.
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	not a Benefit.	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.
D4270	Pedicle soft tissue graft procedure	not a Benefit.	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).
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	not a Benefit.	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).
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 a Benefit.
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) –	not a Benefit.	One surgery per site per 36-month period.

Code	Description	Pediatric Limitation	Adult Limitation
	each additional contiguous tooth, implant or edentulous tooth position in same graft site		
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 a Benefit.
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.	Once per quadrant per 24-month period. Two quadrants per visit maximum.
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.	Once per quadrant per 24-month period.
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.		Not a Benefit.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	for Members age 13 or older.	Once every 3 years.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	for Members age 13 or older.	
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.	Once every 6-month period following active periodontal therapy (exclusive of D4355). Not a Benefit within the first 4 weeks following periodontal treatment.
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).	Not a Benefit.
D4999	Unspecified periodontal procedure, by report	for Members age 13 or older.	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.
Prosthodontics, removable Procedures (D5000-D5899)			
D5110	Complete denture – maxillary	once in a 5 year period from a previous complete, immediate or overdenture-	Once per 5 years.

Code	Description	Pediatric Limitation	Adult Limitation
		complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.	
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.	Once per 5 years.
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.	Once per 5 years.
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.	Once per 5 years.
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		once per 5 years.
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		once per 5 years.
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		once per 5 years.
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		once per 5 years.
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).	once per five years.
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.	once per five years.

Code	Description	Pediatric Limitation	Adult Limitation
		Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	
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).	once per five years.
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).	once per five years.
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	not a Benefit.	Once per 5 years. A Benefit for Members age 21 years and older.
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	not a Benefit.	Once per 5 years. A Benefit for Members age 21 years and older.
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	not a Benefit.	Once per five years.
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	not a Benefit.	Once per five years.
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant	not a Benefit.	Not a Benefit.
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant	not a Benefit.	Not a Benefit.
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-	Once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5110, D5130) or relined (D5730, D5750).

Code	Description	Pediatric Limitation	Adult Limitation
		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).	
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).	Once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5120, D5140) or relined (D5731, D5751).
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).	Once per 6-month period per prosthesis. Not a Benefit for 6 months after denture placed (D5211, D5213) or relined (D5740, D5760).
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:	Once per 6-month period per prosthesis.

Code	Description	Pediatric Limitation	Adult Limitation
		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).	
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).	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
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).	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
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.	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
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).	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).
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	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).

Code	Description	Pediatric Limitation	Adult Limitation
		mandibular partial denture (laboratory) (D5761).	
D5621	Repair cast framework, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider.	Once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5213, D5214).
D5622	Repair cast framework, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider.	Once per 6-month period per prosthesis. Maximum of 3 for 5 years. Not a Benefit for six months after denture placed (D5213, D5214).
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.	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).
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.	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).
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.	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).
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.	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).
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	not a Benefit.	Once per 5 years. A Benefit for Members age 21 years and older.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	not a Benefit.	Once per 5 years. A Benefit for Members age 21 years and older.
D5710	Rebase complete maxillary denture	not a Benefit.	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.
D5711	Rebase complete mandibular denture	not a Benefit.	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.
D5720	Rebase maxillary partial denture	not a Benefit.	Once per 12-month period per procedure. Not a Benefit for the first 12 months after new denture delivery.

Code	Description	Pediatric Limitation	Adult Limitation
D5721	Rebase mandibular partial denture	not a Benefit.	Once per 12-month period per procedure. Not a Benefit for the first 12 months after new denture delivery.
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5110, D5130).
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5120, D5140).
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5211, D5213).
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5212, D5214).
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	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5110, D5130).

Code	Description	Pediatric Limitation	Adult Limitation
		require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).	
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (5120, 5140).
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5211, D5213).
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).	Once per 12-month period per procedure. Not a Benefit for six months after denture placed (D5212, D5214).
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.	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.
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	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.

Code	Description	Pediatric Limitation	Adult Limitation
		mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	
D5862	Precision attachment, by report		not a Benefit.
D5863	Overdenture – complete maxillary	once in a 5 year period.	Not a Benefit.
D5864	Overdenture – partial maxillary	once in a 5 year period.	Not a Benefit.
D5865	Overdenture – complete mandibular	once in a 5 year period.	Not a Benefit.
D5866	Overdenture – partial mandibular	once in a 5 year period.	Not a Benefit.
D5876	Add metal substructure to acrylic full denture (per arch)	not a Benefit.	Not a Benefit.
D5899	Unspecified removable prosthodontic procedure, by report		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.
Maxillofacial Prosthetics Procedures (D5900-D5999)			
D5911	Facial moulage (sectional)		not a Benefit.
D5912	Facial moulage (complete)		not a Benefit.
D5913	Nasal prosthesis		not a Benefit.
D5914	Auricular prosthesis		not a Benefit.
D5915	Orbital prosthesis		not a Benefit.
D5916	Ocular prosthesis	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	not a Benefit.
D5919	Facial prosthesis		not a Benefit.
D5922	Nasal septal prosthesis		not a Benefit.
D5923	Ocular prosthesis, interim	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	not a Benefit.
D5924	Cranial prosthesis		not a Benefit.
D5925	Facial augmentation implant prosthesis		not a Benefit.
D5926	Nasal prosthesis, replacement		not a Benefit.
D5927	Auricular prosthesis, replacement		not a Benefit.
D5928	Orbital prosthesis, replacement		not a Benefit.
D5929	Facial prosthesis, replacement		not a Benefit.
D5931	Obturator prosthesis, surgical	not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).	not a Benefit.
D5932	Obturator prosthesis, definitive	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).	not a Benefit.
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).	not a Benefit.
D5934	Mandibular resection prosthesis with guide flange		not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D5935	Mandibular resection prosthesis without guide flange		not a Benefit.
D5936	Obturator prosthesis, interim	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).	not a Benefit.
D5937	Trismus appliance (not for TMD treatment)		not a Benefit.
D5951	Feeding aid	for Members under the age of 18 only.	not a Benefit.
D5952	Speech aid prosthesis, pediatric	for Members under the age of 18 only.	not a Benefit.
D5953	Speech aid prosthesis, Adult	for Members under the age of 18 only.	not a Benefit.
D5954	Palatal augmentation prosthesis		not a Benefit.
D5955	Palatal lift prosthesis, definitive	not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).	not a Benefit.
D5958	Palatal lift prosthesis, interim	not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).	not a Benefit.
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).	not a Benefit.
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).	not a Benefit.
D5982	Surgical stent		not a Benefit.
D5983	Radiation carrier		not a Benefit.
D5984	Radiation shield		not a Benefit.
D5985	Radiation cone locator		not a Benefit.
D5986	Fluoride gel carrier	a Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.	not a Benefit.
D5987	Commissure splint		not a Benefit.
D5988	Surgical splint		not a Benefit.
D5991	Vesiculobullous disease medicament carrier		not a Benefit.
D5999	Unspecified maxillofacial prosthesis, by report		not a Benefit.
Implant Service Procedures (D6000-D6199)			
D6010	Surgical placement of implant body: endosteal implant		not a Benefit.
D6011	Surgical access to an implant body (second stage implant surgery)		not a Benefit.
D6013	Surgical placement of mini implant		not a Benefit.
D6040	Surgical placement: eposteal implant		not a Benefit.
D6050	Surgical placement: transosteal implant		not a Benefit.
D6055	Connecting bar - implant supported or abutment supported		not a Benefit.
D6056	Prefabricated abutment - includes modification and placement		not a Benefit.
D6057	Custom fabricated abutment - includes placement		not a Benefit.
D6058	Abutment supported porcelain/ceramic crown		not a Benefit.
D6059	Abutment supported porcelain fused to metal crown (high noble metal)		not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)		not a Benefit.
D6061	Abutment supported porcelain fused to metal crown (noble metal)		not a Benefit.
D6062	Abutment supported cast metal crown (high noble metal)		not a Benefit.
D6063	Abutment supported cast metal crown (predominantly base metal)		not a Benefit.
D6064	Abutment supported cast metal crown (noble metal)		not a Benefit.
D6065	Implant supported porcelain/ceramic crown		not a Benefit.
D6066	Implant supported crown – fused to high noble alloys		not a Benefit.
D6067	Implant supported crown – high noble alloys		not a Benefit.
D6068	Abutment supported retainer for porcelain/ceramic FPD		not a Benefit.
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		not a Benefit.
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		not a Benefit.
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)		not a Benefit.
D6072	Abutment supported retainer for cast metal FPD (high noble metal)		not a Benefit.
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)		not a Benefit.
D6074	Abutment supported retainer for cast metal FPD (noble metal)		not a Benefit.
D6075	Implant supported retainer for ceramic FPD		not a Benefit.
D6076	Implant supported retainer FPD – fused to high noble alloys		not a Benefit.
D6077	Implant supported retainer metal FPD - high noble alloys		not a Benefit.
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments		not a Benefit.
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		not a Benefit.
D6082	Implant supported crown - porcelain fused to predominantly base alloys		not a Benefit.
D6083	Implant supported crown - porcelain fused to noble alloys		not a Benefit.
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys		not a Benefit.
D6085	Provisional implant crown		not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D6086	Implant supported crown - predominantly base alloys		not a Benefit.
D6087	Implant supported crown - noble alloys		not a Benefit.
D6088	Implant supported crown - titanium and titanium alloys		not a Benefit.
D6090	Repair implant supported prosthesis, by report		not a Benefit.
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		not a Benefit.
D6092	Re-cement or re-bond implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.	not a Benefit.
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.	not a Benefit.
D6094	Abutment supported crown – titanium and titanium alloys		not a Benefit.
D6095	Repair implant abutment, by report		not a Benefit.
D6096	Remove broken implant retaining screw		not a Benefit.
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys		not a Benefit.
D6098	Implant supported retainer - porcelain fused to predominantly base alloys		not a Benefit.
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys		not a Benefit.
D6100	Implant removal, by report		not a Benefit.
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary		not a Benefit.
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular		not a Benefit.
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary		not a Benefit.
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular		not a Benefit.
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary		not a Benefit.
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular		not a Benefit.
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary		not a Benefit.
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular		not a Benefit.
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		not a Benefit.
D6121	Implant supported retainer for metal FPD – predominantly base alloys		not a Benefit.
D6122	Implant supported retainer for metal FPD – noble alloys		not a Benefit.
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		not a Benefit.
D6190	Radiographic/surgical implant index, by report		not a Benefit.
D6191	Semi-precision abutment – placement		not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D6192	Semi-precision attachment – placement		not a Benefit.
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys		not a Benefit.
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys		not a Benefit.
D6199	Unspecified implant procedure, by report		not a Benefit.
Prosthodontics, fixed Procedures (D6200-D6999)			
D6205	Pontic – indirect resin based composite	not a Benefit.	Once per five years per tooth.
D6210	Pontic – cast high noble metal	not a Benefit.	Once per five years per tooth.
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.	Once per five years per tooth.
D6212	Pontic – cast noble metal	not a Benefit.	Once per five years per tooth.
D6214	Pontic – titanium and titanium alloys	not a Benefit.	Once per five years per tooth.
D6240	Pontic – porcelain fused to high noble metal	not a Benefit.	Once per five years per tooth.
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.	Once per five years per tooth.

Code	Description	Pediatric Limitation	Adult Limitation
D6242	Pontic – porcelain fused to noble metal	not a Benefit.	Once per five years per tooth.
D6243	Pontic – porcelain fused to titanium and titanium alloys	not a Benefit.	Once per five years per tooth.
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.	Not a Benefit.
D6250	Pontic - resin with high noble metal	not a Benefit.	Not a Benefit.
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.	Not a Benefit.
D6252	Pontic - resin with noble metal	not a Benefit.	Not a Benefit.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	not a Benefit.	Not a Benefit.
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	not a Benefit.	Not a Benefit.
D6549	Retainer – for resin bonded fixed prosthesis	not a Benefit.	Not a Benefit.
D6608	Retainer onlay - porcelain/ceramic, two surfaces	not a Benefit.	Once per five years per tooth.
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	not a Benefit.	Once per five years per tooth.
D6610	Retainer onlay - cast high noble metal, two surfaces	not a Benefit.	Once per five years per tooth.
D6611	Retainer onlay - cast high noble metal, three or more surfaces	not a Benefit.	Once per five years per tooth.
D6612	Retainer onlay - cast predominantly base metal, two surfaces	not a Benefit.	Once per five years per tooth.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	not a Benefit.	Once per five years per tooth.

Code	Description	Pediatric Limitation	Adult Limitation
D6614	Retainer onlay - cast noble metal, two surfaces	not a Benefit.	Once per five years per tooth.
D6615	Retainer onlay - cast noble metal, three or more surfaces	not a Benefit.	Once per five years per tooth.
D6634	Retainer onlay - titanium	not a Benefit.	Not a Benefit.
D6710	Retainer crown - indirect resin based composite	not a Benefit.	Once per five years per tooth.
D6720	Retainer crown - resin with high noble metal	not a Benefit.	Not a Benefit.
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.	Not a Benefit.
D6722	Retainer crown - resin with noble metal	not a Benefit.	Not a Benefit.
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.	Not a Benefit.
D6750	Retainer crown – porcelain fused to high noble metal	not a Benefit.	Once per five years per tooth.
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.	Once per five years per tooth.
D6752	Retainer crown – porcelain fused to noble metal	not a Benefit.	Once per five years per tooth.
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	not a Benefit.	Once per five years per tooth.
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.	Once per five years per tooth.
D6782	Retainer crown – 3/4 cast noble metal	not a Benefit.	Once per five years per tooth.
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.	Not a Benefit.
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).	Once per five years per tooth.

Code	Description	Pediatric Limitation	Adult Limitation
		Not a Benefit for Members under the age of 13.	
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.	Once per five years per tooth.
D6794	Retainer crown – titanium and titanium alloys	not a Benefit.	Not a Benefit.
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.	Once per six months per bridge.
D6980	Fixed partial denture repair necessitated by restorative material failure	not a Benefit within 12 months of initial placement or previous repair, same provider.	Once per 6-month period per bridge.
D6999	Unspecified fixed prosthodontic procedure, by report		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.
Oral Maxillofacial Prosthetics Procedures (D7000-D7999)			
D7111	Extraction, coronal remnants – deciduous tooth	not a Benefit for asymptomatic teeth.	Once per tooth.
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.	Once per tooth.
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.	Once per tooth.
D7220	Removal of impacted tooth – soft tissue	a Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.	Once per tooth.
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.	Once per tooth.
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.	Once per tooth.
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	Once per tooth.

Code	Description	Pediatric Limitation	Adult Limitation
		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.	
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.	Once per tooth.
D7260	Oroantral fistula closure	a Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.	Once per tooth per lifetime.
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.	Not a Benefit.
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.	
D7280	Exposure of an unerupted tooth	not a Benefit: a. for Members age 21 or older, or b. for 3rd molars.	
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.	
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.	Not a Benefit.
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	
D7287	Exfoliative cytological sample collection	not a Benefit.	
D7288	Brush biopsy - transepithelial sample collection	not a Benefit.	
D7290	Surgical repositioning of teeth	for permanent teeth only; once per arch; and only for Members in active orthodontic treatment.	Not a Benefit.
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	once per arch and only for Members in active orthodontic treatment.	Not a Benefit.
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.	Once per tooth per 36- month period. A Benefit when performed in conjunction with >4 extractions in the same area.
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		once per tooth per 36- month period. A Benefit when performed in conjunction with >4 extractions in the same area.

Code	Description	Pediatric Limitation	Adult Limitation
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.	Once per tooth per 36- month period. Not a Benefit on same date of service as D7110-D7250.
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		once per tooth per 36- month period. Not a Benefit on same date of service as D7110-D7250.
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	once in a 5 year period per arch.	Not a Benefit.
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.	Not a Benefit.
D7410	Excision of benign lesion up to 1.25 cm		not a Benefit.
D7411	Excision of benign lesion greater than 1.25 cm		not a Benefit.
D7412	Excision of benign lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	Not a Benefit.
D7413	Excision of malignant lesion up to 1.25 cm		not a Benefit.
D7414	Excision of malignant lesion greater than 1.25 cm		not a Benefit.
D7415	Excision of malignant lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	Not a Benefit.
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm		not a Benefit.
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm		not a Benefit.
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		once per site per lifetime.
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		once per site per lifetime.
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		not a Benefit.
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		not a Benefit.
D7465	Destruction of lesion(s) by physical or chemical method, by report		not a Benefit.
D7471	Removal of lateral exostosis (maxilla or mandible)	once per quadrant and for the removal of buccal or facial exostosis only.	One surgery per site per 36-month period.
D7472	Removal of torus palatinus	once in the Member's lifetime.	One surgery per site per 36-month period.
D7473	Removal of torus mandibularis	once per quadrant.	One surgery per site per 36-month period.
D7485	Reduction of osseous tuberosity	once per quadrant.	Not a Benefit.
D7490	Radical resection of maxilla or mandible		not a Benefit.
D7510	Incision and drainage of abscess – intraoral soft tissue	once per quadrant, same date of service.	Not a Benefit in conjunction with the extraction of same tooth (D7110-D7240) on same date of service.
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	once per quadrant, same date of service.	Not a Benefit in conjunction with the extraction of same tooth (D7110-D7240) on same date of service.

Code	Description	Pediatric Limitation	Adult Limitation
D7520	Incision and drainage of abscess – extraoral soft tissue		not a Benefit.
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		not a Benefit.
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).	Not a Benefit.
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).	Not a Benefit.
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).	Not a Benefit.
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.	Not a Benefit.
D7610	Maxilla – open reduction (teeth immobilized, if present)		not a Benefit.
D7620	Maxilla – closed reduction (teeth immobilized, if present)		not a Benefit.
D7630	Mandible – open reduction (teeth immobilized, if present)		not a Benefit.
D7640	Mandible – closed reduction (teeth immobilized, if present)		not a Benefit.
D7650	Malar and/or zygomatic arch – open reduction		not a Benefit.
D7660	Malar and/or zygomatic arch – closed reduction		not a Benefit.
D7670	Alveolus – closed reduction, may include stabilization of teeth		not a Benefit.
D7671	Alveolus – open reduction, may include stabilization of teeth		not a Benefit.
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	for the treatment of simple fractures only.	Not a Benefit.
D7710	Maxilla – open reduction		not a Benefit.
D7720	Maxilla – closed reduction		not a Benefit.
D7730	Mandible – open reduction		not a Benefit.
D7740	Mandible – closed reduction		not a Benefit.
D7750	Malar and/or zygomatic arch – open reduction		not a Benefit.
D7760	Malar and/or zygomatic arch – closed reduction		not a Benefit.
D7770	Alveolus – open reduction stabilization of teeth		not a Benefit.
D7771	Alveolus – closed reduction stabilization of teeth		not a Benefit.
D7780	Facial bones – complicated reduction with fixation and multiple approaches	for the treatment of compound fractures only.	Not a Benefit.
D7810	Open reduction of dislocation		not a Benefit.
D7820	Closed reduction of dislocation		not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D7830	Manipulation under anesthesia		not a Benefit.
D7840	Condylectomy		not a Benefit.
D7850	Surgical discectomy, with/without implant		not a Benefit.
D7852	Disc repair		not a Benefit.
D7854	Synovectomy		not a Benefit.
D7856	Myotomy		not a Benefit.
D7858	Joint reconstruction		not a Benefit.
D7860	Arthrotomy		not a Benefit.
D7865	Arthroplasty		not a Benefit.
D7870	Arthrocentesis		not a Benefit.
D7871	Non-arthroscopic lysis and lavage		not a Benefit.
D7872	Arthroscopy – diagnosis, with or without biopsy		not a Benefit.
D7873	Arthroscopy – lavage and lysis of adhesions		not a Benefit.
D7874	Arthroscopy – disc repositioning and stabilization		not a Benefit.
D7875	Arthroscopy – synovectomy		not a Benefit.
D7876	Arthroscopy – discectomy		not a Benefit.
D7877	Arthroscopy – debridement		not a Benefit.
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.	Not a Benefit.
D7881	Occlusal orthotic device adjustment		not a Benefit.
D7899	Unspecified TMD therapy, by report	not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.	Not a Benefit.
D7910	Suture of recent small wounds up to 5 cm	not a Benefit for the closure of surgical incisions.	Not a Benefit.
D7911	Complicated suture – up to 5 cm	not a Benefit for the closure of surgical incisions.	Not a Benefit.
D7912	Complicated suture – greater than 5 cm	not a Benefit for the closure of surgical incisions.	Not a Benefit.
D7920	Skin graft (identify defect covered, location and type of graft)	not a Benefit for periodontal grafting.	Not a Benefit.
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site		not a Benefit.
D7940	Osteoplasty – for orthognathic deformities		not a Benefit.
D7941	Osteotomy – mandibular rami		not a Benefit.
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		not a Benefit.
D7944	Osteotomy – segmented or subapical		not a Benefit.
D7945	Osteotomy – body of mandible		not a Benefit.
D7946	LeFort I (maxilla – total)		not a Benefit.
D7947	LeFort I (maxilla – segmented)		not a Benefit.
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft		not a Benefit.
D7949	LeFort II or LeFort III – with bone graft		not a Benefit.
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	not a Benefit for periodontal grafting.	Not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	only for Members with authorized implant services.	Not a Benefit.
D7952	Sinus augmentation via a vertical approach	only for Members with authorized implant services.	Not a Benefit.
D7955	Repair of maxillofacial soft and/or hard tissue defect	not a Benefit for periodontal grafting.	Not a Benefit.
D7961	Buccal / labial frenectomy (frenulectomy)	once per arch per date of service and only when the permanent incisors and cuspids have erupted.	once per site per lifetime.
D7962	Lingual frenectomy (frenulectomy)	once per arch per date of service and only when the permanent incisors and cuspids have erupted.	once per site per lifetime.
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.	once per site per lifetime.
D7970	Excision of hyperplastic tissue – per arch	once per arch per date of service.	once per site per 36-month period.
D7971	Excision of pericoronal gingiva		once per site per lifetime.
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.	not a Benefit.
D7979	Non-surgical Sialolithotomy		not a Benefit.
D7980	Sialolithotomy		not a Benefit.
D7981	Excision of salivary gland, by report		not a Benefit.
D7982	Sialodochoplasty		not a Benefit.
D7983	Closure of salivary fistula		not a Benefit.
D7990	Emergency tracheotomy		not a Benefit.
D7991	Coronoidectomy		not a Benefit.
D7995	Synthetic graft – mandible or facial bones, by report	not a Benefit for periodontal grafting.	not a Benefit.
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.	not a Benefit.
D7999	Unspecified oral surgery procedure, by report		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.
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).	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.	not a Benefit.
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.	not a Benefit.
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.
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.
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.
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.
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.
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.
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.
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.
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.
D8681	Removable orthodontic retainer adjustment		not a Benefit.
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.
D8697	Repair of orthodontic appliance – mandibular	once per appliance.	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
		Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8698	Re-cement or re-bond fixed retainer – maxillary	once per provider.	not a Benefit.
D8699	Re-cement or re-bond fixed retainer – mandibular	once per provider.	not a Benefit.
D8701	Repair of fixed retainer, includes reattachment – maxillary		not a Benefit.
D8702	Repair of fixed retainer, includes reattachment – mandibular		not a Benefit.
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.
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.
D8999	Unspecified orthodontic procedure, by report		not a Benefit.
Adjunctive General Services (D9000-D9999)			
D9110	Palliative (emergency) treatment of dental pain – minor procedure	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.	once per month for same condition.
D9120	Fixed partial denture sectioning	a Benefit when at least one of the abutment teeth is to be retained.	not a Benefit.
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.	two per visit.
D9211	Regional block anesthesia		
D9212	Trigeminal division block anesthesia		
D9215	Local anesthesia in conjunction with operative or surgical procedures		
D9222	Deep sedation/analgesia - 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.	
D9223	Deep sedation/general anesthesia - each 15 minute increment		maximum of additional 30 minutes per visit.

Code	Description	Pediatric Limitation	Adult Limitation
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.	not a Benefit.
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.	not a Benefit.
D9243	Intravenous moderate (conscious) sedation/analgesia - each 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.	maximum of additional 30 minutes per visit.
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.	not a Benefit.
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		once per year for the same condition.
D9311	Consultation with a medical health professional		

Code	Description	Pediatric Limitation	Adult Limitation
D9410	House/extended care facility call	once per Member per date of service and only in conjunction with procedures that are payable.	not a Benefit.
D9420	Hospital or ambulatory surgical center call	a Benefit for each hour or fraction thereof as documented on the operative report.	not a Benefit.
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.	not a Benefit.
D9440	Office visit – after regularly scheduled hours	once per date of service per provider and only with treatment that is a Benefit.	not a Benefit.
D9450	Case presentation, detailed and extensive treatment planning	not a Benefit.	not a Benefit.
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.	not a Benefit.
D9612	Therapeutic parenteral drugs, two or more administrations, different medications		not a Benefit.
D9910	Application of desensitizing medicament	once in a 12 month period per provider and for permanent teeth only.	two (2) applications on any number of teeth per 12-month period.
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.	not a Benefit.
D9942	Repair and/or reline of occlusal guard	not a Benefit.	once per 12-month period.
D9943	Occlusal guard adjustment	not a Benefit.	once per 12-month period (6 months after initial placement).
D9944	Occlusal guard – hard appliance, full arch	not a Benefit.	once per 2 years, Not a Benefit for TMJ pain or treatment.
D9945	Occlusal guard – soft appliance, full arch	not a Benefit.	once per 2 years, Not a Benefit for TMJ pain or treatment.
D9946	Occlusal guard – hard appliance, partial arch	not a Benefit.	once per 2 years, Not a Benefit for TMJ pain or treatment.
D9950	Occlusion analysis – mounted case	once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ	not a Benefit.

Code	Description	Pediatric Limitation	Adult Limitation
		dysfunction only; and for permanent dentition. Not a Benefit for bruxism only.	
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.	not a Benefit.
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.	not a Benefit.
D9995	Teledentistry – synchronous; real-time encounter	not a Benefit.	not a Benefit.
D9996	Teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review	not a Benefit.	not a Benefit.
D9997	Dental case management – patients with special health care needs		
D9999	Unspecified adjunctive procedure, by report		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.

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Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Blue Shield of California is an independent member of the Blue Shield Association A49726-DMHC (12/19)

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíínííłta'go bííníghah? Doo bííníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolnííł nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíílnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສໍາຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສໍາລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)