

**Indemnity Schedule of Allowances for Dental
Procedures As Revised January 1, 2008
Gold and Platinum Plans
Benefits, Limitations and Exclusions, including
Miscellaneous Codes**

IMPORTANT NOTICE: FOR PARTICIPANTS WITH MORE THAN 24 MONTHS OF DENTAL ELIGIBILITY:
[1] The first \$75 of expenses per person covered under this schedule will be deducted for services per calendar year up to \$225 per family. This deductible will not apply to routine preventive and diagnostic care such as oral examinations, teeth cleanings and x-rays. [2] An annual benefit maximum of \$1,500 per person covered under this schedule will apply. The allowance for all covered services will be 100% of the benefit schedule.

IMPORTANT NOTICE: FOR PARTICIPANTS WITH LESS THAN 24 MONTHS OF DENTAL ELIGIBILITY:
[1] The first \$100 of expenses per person covered under this schedule will be deducted for services per calendar year up to \$300 per family. This deductible will not apply to routine preventive and diagnostic care such as oral examinations, teeth cleanings and x-rays. [2] An annual benefit maximum of \$500 per person covered under this schedule will apply. The allowance for diagnostic and preventive will be 100% of the benefit schedule; all other services will be paid at 66 2/3% of the benefit schedule.

I GENERAL INFORMATION

201. Covered dental benefits are those listed procedures necessary to prevent and eliminate oral disease and for services required to maintain and restore function. The Indemnity Schedule of Allowances for Dental Procedures indicates the dollar amount the Fund will contribute toward the dentist's fee for each listed procedure, but in no event will the Fund's allowance exceed the fee charged. For participants with more than 24 months of dental eligibility, the first \$75 of expenses per person under this schedule will be deducted for services per calendar year up to a maximum of \$225 per family. This deductible will not apply to routine preventive and diagnostic care such as oral examinations, teeth cleanings and x-rays. For participants with more than 24 months of dental eligibility the annual maximum benefit per person is \$1,500.
202. Covered benefits are subject to review by the dental consultants for the Fund. Preauthorization for treatment plans in excess of \$500 is required and will be allowed only when patient need can be demonstrated. X-rays are required on all claims over \$500 and for claims under \$500 when extractions, crowns, periodontal treatment, root canal therapy, or 3 or more restorations are involved.
203. Eligibility on dental claim forms is subject to continued employment. Coverage terminates at the end of the month last worked in covered employment unless coverage is continued due to receipt of supplemental unemployment or disability benefits or Cobra Continuation Coverage.
204. Claims must be submitted within twelve months after completion of compensable dental procedures and must show procedure codes (adapted from the ADA recommended Current Dental Terminology CDT) and actual fee charge to the patient.

205. The Benefit Fund will not process requests for partial payment. Payment will be made only for services previously authorized and completed at the time of payment request.
206. Coordination of Benefit Provision will be applied in the payment of all claims. This Plan will coordinate with all other group plans.
207. Charge for completion of forms is not a covered benefit.
208. Payment will not be made for x-rays that are not diagnostically acceptable.
209. Orthodontics and related services are an exclusion. Effective September 1, 2004 the Fund no longer will cover this service.
210. Dental treatment performed for cosmetic or aesthetic reasons is not a covered benefit.
211. Full mouth reconstruction or treatment for congenital malformations is not a covered benefit.
212. Hospitalized dental treatment is not a covered benefit.
215. Charges made by (a) immediate relatives of the participant or dependent or (b) members of the participant's or dependent's households are not covered, except for covered charges, which constitute out-of-pocket expenses to such providers.

II DIAGNOSTIC

216. Examinations or oral evaluations are a covered benefit once per six months, except in emergency situations.
217. X-rays must be dated, properly mounted, and diagnostically acceptable.
218. Occlusal or panoramic x-rays are required for edentulous patients.
219. Full mouth or panoramic x-rays are covered benefits only once every five years.
220. A panoramic x-ray when accompanied by two or more bitewing and/or periapical anterior films is considered the same as a full mouth x-ray series and is paid as such.
221. Study models or intra-oral photographs are not a covered benefit, unless requested by Fund Consultant.
222. Bitewing and recall periapical x-rays are a covered benefit once every twelve months.

III PREVENTIVE

225. Dental prophylaxis is a covered benefit only once in six month period unless need for greater frequency can be demonstrated.
226. Prophylaxis and subgingival scaling are not payable on same day/visit.
227. Fluoride treatment is a covered benefit only once per six month period for persons under 19 years of age.
228. Dietary planning for the control of dental caries is not covered.
229. Oral hygiene instructions, plaque control, sealants or preventive programs are not covered.
230. Where a fixed space maintainer can be placed, removable spacers are not a covered benefit, unless authorized by report.
231. Where bilateral space maintenance is required in the same arch, a bilateral space maintainer with molar bands connected by an arch wire is the covered benefit.
232. Space maintainers are not a covered benefit when spaces have closed or crowns of erupting teeth have penetrated alveolar bone.
233. A benefit is payable for a unilateral space maintainer when a bilateral space maintainer is not necessary.

IV RESTORATIVE

234. Maximum payment for anterior restorations is two surfaces in each course of treatment regardless of the number of combinations placed.
235. Amalgam or composite fillings are a covered benefit once every two years.
236. Proximal restorations in anterior teeth are payable as single surface restoration,
237. Payment is not covered for more than one restoration on a single tooth surface per treatment.
238. A benefit for a one surface restoration is allowed when a buccal and/or lingual surface restoration is placed in conjunction with occlusal surface restorations.

- 239. Placement of crowns/bridges following endodontic therapy will be delayed pending submission of radiographic evidence (pre and post treatment x-rays) of satisfactory root canal therapy.
- 240. Restoration will not be a covered benefit when carious penetration to or through the dento-enamel junction is not evident from the submitted x-rays or when primary teeth are exfoliating or about to exfoliate.
- 241. Where there appears to be a questionable long-term prognosis restorative or periodontal procedures and root canal therapy are not a covered benefit.
- 242. Benefits are not payable for the placement of composite restorations on posterior teeth except the facial surfaces of premolars and the maxillary first molars, allowance will be made for equivalent to amalgam restoration benefits.

V ENDODONTICS

- 243. The benefit allowed for endodontic therapy includes initial treatment, interim and final x-rays and temporary fillings.
- 244. Pulp caps and bases are not a benefit. The fee for the final restoration includes cement bases and/or pulp caps.
- 245. Benefits payable for endodontic therapy will be delayed pending submission of radiographic evidence (pre and post treatment x-rays) of satisfactory root canal therapy.
- 246. No payment is made where the need for root canal procedures are not evident radiographically or from the documentation submitted.
- 247. Re-treatment of root canal therapy is a covered benefit only if need is documented and no sooner than twelve months after initial treatment or by report.
- 248. Benefits have been reduced by a previous allowance for palliative, pulpal debridement or emergency treatment.

VI PERIODONTICS

- 249. Occlusal adjustments are not a covered benefit.
- 250. Periodontal splinting is not a covered benefit.
- 251. Periodontal scaling and root planing is a covered benefit only where x-rays demonstrate bone loss and root surface calculus.
- 252. Periodontal surgery is covered after scaling and root planing and when need is documented by pretreatment x-rays and pre and post periodontal scaling and root planing pocket charting.
- 253. Mouth preparation services in conjunction with mucogingival or osseous surgery are classified as subgingival scalings.
- 254. Periodontal scaling and root planing is limited to a maximum of two procedures per visit.
- 255. Benefits for periodontal scaling and root planing are payable once per quadrant in a two year period.
- 256. Periodontal surgery is a covered benefit once in a two-year period.

VII PROSTHODONTICS, REMOVABLE

- 257. Full dentures are not a covered benefit when partial dentures can be placed.
- 259. The fee allowed for a partial denture includes all teeth and clasps.
- 260. Treatment involving the following is not a covered benefit:
 - a. Specialized techniques.
 - b. Precision attachments and stress breakers.
 - c. Personalization & Characterization.
 - d. Experimental procedures.
 - e. Surgical correction by grafts for denture retention purposes.
 - f. Appliances or restorations to increase vertical dimension.
 - g. Gnathologic recording.
 - h. Unusual diagnostic techniques.
 - i. Procedures associated with overdentures, implants and tissue bars.
- 261. Removable cast partial dentures are not a benefit for patients under age 16 unless need is substantiated by special report. Allowance will be made for an acrylic partial.
- 262. Fixed or removable prosthetic appliances are a covered benefit once in a five year period.
- 264. Interim partial dentures are covered for recently extracted anterior teeth only.

VIII PROSTHODONTICS, FIXED

- 266. Benefits for crowns, inlays and onlays are allowable only where extensive coronal destruction is radiographically demonstrated or can be demonstrated by study models or photographs.
- 267. Amalgam or composite resin buildups, including pins, are considered part of the preparation for the complete restoration. No additional benefit is payable.
- 268. Posts and cores are a benefit where insufficient coronal structure remains to retain a crown and can be documented by pre-root canal x-rays. When allowed, they are a covered benefit once in a five-year period.
- 270. Fixed bridges are not a benefit for patients under the age of 16.
- 271. Fixed bridges using implants as abutments is not a covered benefit.
- 272. Porcelain, cast metal, or laboratory-processed restorations are not a benefit for patients under 16 years of age.
- 273. Benefits are not payable for both a posterior bridge and a removable partial denture in the same arch within a five-year period.
- 274. Distal extension posterior cantilevered pontics are not a covered benefit.
- 275. Where the space is largely closed, fixed bridgework is not a covered benefit.
- 276. The replacement of second molars is not covered unless as part of a bridge replacing first molars.
- 277. Gnathologic recording is not a covered benefit.
- 278. Where a large number of teeth are missing in the same arch and/or moderate to advanced periodontal bone loss is evident radiographically, fixed prostheses is not a covered benefit.
- 280. Cast and indirect restorations or fixed bridges are a covered benefit once in a five-year period.
- 281. Where a filling requires replacement with a cast restoration within one year of placement, the allowance paid for the filling will be deducted from the cast restoration benefit.

IX ORAL SURGERY

- 285. The removal of teeth that can be retained to avoid the conversion of a patient to partial or complete edentulism is not a covered benefit.
- 286. Removal of unerupted, nonpathologic asymptomatic third molars is not a covered benefit.
- 287. Implants are not a covered benefit. (See Limitation #332)
- 288. Routine postoperative visits are considered part of, and included in the allowance for the total surgical procedure.
- 289. General anesthesia is a covered benefit for medically necessary and complex procedures only, if administered by a health care provider with a current general anesthesia permit number.

X ADJUNCTIVE

- 290. Pre-medication and/or relative analgesia is not covered except for documented handicapped or uncontrollable patients.

XI MISCELLANEOUS BENEFIT LIMITATIONS, EXCLUSIONS AND CODES

- 291. Where a crown and/or bridge repair can be done, allowance will be made for repairs in lieu of replacement.
- 292. Benefit applied to overpayment of previous claim for self or other family member.
- 293. Insufficient documentation of need submitted.
- 294. No allowance can be made for the service provided this tooth as our records show the tooth is missing.
- 295. Partial denture allowance has been made in lieu of fixed bridge benefits (see limitations #278). That allowance may be applied to the cost of the bridge if it is completed.
- 296. Allowance has been made for a filling in lieu of cast restoration (see limitation #266). That allowance may be applied to the cost of the cast or indirect restoration if it is completed.
- 297. The extraction of primary teeth that are about to exfoliate is not a covered benefit.
- 298. Amalgam benefit will be paid in lieu of composite.
- 299. Palliative treatment is not covered when other treatment is provided the same day.
- 300. Office visits are not a covered benefit.

301. This procedure is not a covered benefit.
302. Prophylaxis benefit will be paid in lieu of submitted service.
304. This procedure has been disallowed based on our consultant's report attached.
305. The classification of extractions have been benefited payable as 7140
307. The classification of extractions have been benefited payable as 7210
308. The classification of extractions have been benefited payable as 7220
309. The classification of extractions have been benefited payable as 7230
310. Member enrolled in pre-paid dental plan and is therefore not eligible for indemnity dental benefits.
311. The Fund has no record of a full time student certificate on file for services provided this date.
312. Primary Participant and Dependent(s) not eligible for benefits.
313. Dependent not eligible at time of service.
314. Benefits for this service limited to once every 3 mos.
315. Benefits for this service limited to once every 4 mos.
316. Benefits for this service limited to once every 6 mos.
317. Benefits for this service limited to once every 12 mos.
318. Benefits for this service limited to once every 24 months.
319. Periodontal maintenance is a covered benefit no less than once every three months and no sooner than three months after periodontal surgery.
320. Maximum benefits have been allowed for this service.
321. Re-submit with the correct CDT procedure code for the service date.
322. Requested information not received, claim review closed.
323. The need for periodontal scaling and root planing has not been documented by the x-rays and periodontal pocket charting.
324. Occlusal guards are a covered benefit only where need can be documented by x-rays, the patient's chief complaint and doctor's diagnosis. Submission of study models may be necessary at the consultant's request. When allowed, they are a covered benefit once in a two-year period.
325. Duplicate submission of previously processed service.
326. Repair and recementation of an inlay, onlay, crown, or fixed bridge is a covered benefit only after twelve months from initial placement.
327. Replacement of prefabricated acrylic or stainless steel crowns is a covered benefit once in a two-year period.
328. Replacement of space maintainers is a covered benefit once in a two-year period.
329. Restoration of tooth structure loss due to abrasion, erosion, or attrition is not a covered benefit.
332. The allowance for an implant supported crown is in lieu of a three unit fixed bridge where such a bridge would be a covered benefit of the Plan.

Southern California Drug Benefit Fund – 2008 Indemnity Dental Benefit Schedule for All Plans

PROCEDURE	Coding	Benefit	PROCEDURE	Coding	Benefit
Surgical revision procedure, per tooth	4268	Not covered	Stress breaker	6940	Not covered
Pedicle soft tissue graft procedure	4270–4273	\$506.00	Precision attachment	6950	Not covered
Distal or proximal wedge	4274	\$385.00	Cast post and core in addition to fixed bridge	6970	\$188.00
Soft tissue allograft	4275	\$506.00	Prefabricated post & core to retain abutment crown	6972	\$175.00
Combined connective tissue and double pedicle graft	4276	\$506.00	Core buildup for retainer, including any pins	6973	Not covered
Provisional splinting – intra & extracoronal	4320 & 4321	Not covered	Coping – metal	6975	Not covered
Scaling/root planing, 4 or more teeth	4341	\$150.00	Fixed partial denture repair, by report	6980	\$197.00
Scaling/root planing, 1–3 teeth	4342	\$99.00	Pediatric partial denture, fixed	6985	Not covered
Full mouth debridement	4355	Not covered			
Localized delivery of chemotherapeutic agents	4381	Not covered	VIII ORAL SURGERY		
Periodontal maintenance, following active therapy	4910	\$77.00	(Including local anesthesia and routine post operative care)		
VI PROSTHODONTICS – REMOVABLE			Extraction, coronal remnants – deciduous tooth	7111	\$80.00
(Including all adjustments within six months following installation)			Extraction, erupted tooth or exposed root	7140	\$100.00
Complete denture	5110–5140	\$907.00	Surgical extraction (erupted)	7210	\$165.00
Partial–resin base (including clasps)	5211–5212	\$805.00	Remove impacted tooth – soft tissue	7220	\$200.00
Partial–cast metal frame & resin			Remove impacted tooth – partially bony	7230	\$255.00
base (clasps, teeth, rests)	5213–5214	\$1,000.00	Remove impacted tooth – completely bony	7240	\$300.00
Partial denture – flexible base	5225–5226	\$900.00	Remove impacted tooth – completely bony complex	7241	\$322.00
Removable unilateral partial, one piece			Surgical removal of residual tooth roots	7250	\$178.50
cast (clasps & teeth)	5281	\$501.00	Surgical access of an unerupted tooth	7280	\$290.00
Adjust complete denture	5410–5411	\$64.50	Placement of device to facilitate eruption of impacted tooth	7283	\$310.00
Adjust partial denture	5421–5422	\$64.50	Biopsy of oral tissue – hard	7285	\$209.00
Repair broken denture base (no broken teeth) - full	5510	\$120.00	Biopsy of oral tissue – soft	7286	\$180.00
Replace missing or broken teeth, each - full	5520	\$113.75	Cytological sample collection	7287	\$80.00
Repair resin denture base - partial	5610	\$115.00	Brush biopsy – transepithelial sample collection	7288	\$80.00
Repair cast framework - partial	5620	\$134.00	Surgical repositioning of teeth	7290	Not covered
Repair or replace broken clasp	5630	\$120.00	Alveoplasty in conjunction with extractions		
Replace missing or broken teeth, each - partial	5640	\$113.75	per quadrant	7310	Not covered
Add tooth to partial denture, each	5650	\$120.00	Alveoplasty, not with extractions, per quadrant	7320	\$172.00
Add clasp to existing partial denture	5660	\$161.00	Alveoplasty, not with extractions 1-3 teeth or space,		
Replace teeth & acrylic on cast metal framework	5670–5671	\$935.00	per quadrant	7321	\$172.00
Rebase complete denture	5710–5711	\$340.00	Vestibuloplasty – ridge extension	7340–7350	Not covered
Rebase partial denture	5720–5721	\$340.00	Removal of odontogenic cyst/tumor to 1.25 cm.	7450	\$390.00
Office reline – complete denture	5730–5731	\$185.00	Removal of odontogenic cyst/tumor 1.25 cm. or larger	7451	\$390.00
Office reline – partial denture	5740–5741	\$185.00	Removal of exostosis & torus	7471–7473	\$390.00
Lab reline – complete denture	5750–5751	\$294.00	Incision & drainage of abscess – intraoral soft tissue	7510	\$130.00
Lab reline – partial denture	5760–5761	\$294.00	Incision & drainage of abscess – intraoral soft tissue		
Interim partial denture	5820–5821	\$322.00	complicated	7511	\$165.00
Tissue conditioning	5850–5851	\$118.00	Incision & drainage of abscess – extraoral soft tissue	7520	\$215.00
Overdenture – complete	5860	\$860.00	Incision & drainage of abscess – extraoral soft tissue		
Overdenture – partial	5861	\$830.00	complicated	7521	\$240.00
Precision attachment	5862	Not covered	Frenulectomy – separate procedure	7960	\$270.00
Replacement of replaceable part of precision attachment	5867	Not covered	Excision of hyperplastic tissue, per arch	7970	\$190.00
Modification of removable prosthesis following implant surgery	5875	Not covered			
VII PROSTHODONTICS – FIXED			IX ADJUNCTIVE GENERAL SERVICES		
Implant supported single crown	6058–6067	\$650.00	Emergency treatment – palliative	9110	\$92.25
(See Limitation #332)	and 6094		Regional block anesthesia	9211	Not covered
Pontics	6205–6252	\$650.00	Trigeminal division block anesthesia	9212	Not covered
Abutments			General anesthesia, first 30 minutes	9220	\$250.00
Retainer–cast metal for resin bonded fixed prosthesis	6545	\$325.00	General anesthesia, each additional 15 minutes	9221	Not covered
Retainer – porcelain for resin bonded fixed bridge	6548	\$325.00	Analgesia, analolysis, nitrous oxide	9230	\$51.50
Porcelain/ceramic inlay/onlay - 2 surfaces	6600 & 6608	\$490.00	Intravenous sedation/analgesia first 30 minutes	9241	\$107.25
Porcelain/ceramic inlay/onlay – 3 surfaces	6601 & 6609	\$580.00	Intravenous sedation/analgesia		
Cast high noble metal inlay/onlay – 2 surfaces	6602 & 6610	\$490.00	each additional 15 minutes	9242	Not covered
Cast high noble metal inlay/onlay – 3 surfaces	6603 & 6611	\$580.00	Non–intravenous conscious sedation	9248	Not covered
Cast base metal inlay/onlay – 2 surfaces	6604 & 6612	\$490.00	Consultation	9310	\$75.25
Cast base metal inlay/onlay – 3 surfaces	6605 & 6613	\$580.00	Case presentation, detailed and extensive treatment planning	9450	Not covered
Cast noble metal inlay/onlay – 2 surfaces	6606 & 6614	\$490.00	Therapeutic drug injection	9610	\$28.50
Cast noble metal inlay/onlay – 3 surfaces	6607 & 6615	\$580.00	Application of desensitizing medicament	9910	Not covered
Titanium inlay/onlay	6624 & 6634	\$580.00	Behavioral management	9920	Not covered
Crown abutment for fixed bridge	6720–6794	\$650.00	Treatment of complication (post–surgical)	9930	Not covered
Recement fixed partial denture	6930	\$92.25	Occlusal guard	9940	\$326.00
			Occlusal adjustment	9951–9952	Not covered