

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

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. The first \$50 of expenses per person under this schedule will be deducted for services per calendar year up to a maximum of \$150 per family. This deductible will not apply to routine preventive and diagnostic care such as oral examinations, teeth cleanings and x-rays.
202. Covered benefits are subject to review by the dental consultants for the Fund. Preauthorization for claims 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. They are covered under a separate program.
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 twelve months.
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 six 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.
- 235a. Amalgam or composite fillings are a covered benefit once every twelve months.
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 or 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.
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.

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
- Specialized techniques.
 - Precision attachments and stress breakers.
 - Personalization & Characterization.
 - Experimental procedures.
 - Surgical correction by grafts for denture retention purposes.
 - Appliances or restorations to increase vertical dimension.
 - Gnathologic recording.
 - Unusual diagnostic techniques.
 - 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.
- 262a. Fixed or removable prosthetic appliances are a covered benefit once in a two-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.
267. Amalgam or composite resin buildups, including pins, are considered part of the preparation for the complete restoration. No additional benefit is payable.
- 268a. Posts and cores are a benefit where insufficient coronal structure remains and can be documented by pre-root canal x-rays. When allowed, they are a covered benefit once in a two-year period.
270. Fixed bridges are not a benefit for patients under age 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.
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 and third molars is not covered unless as part of a bridge restoring other adjacent missing teeth.
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.
- 280a. Cast and indirect restorations or fixed bridges are a covered benefit once in a two-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. Where our records show a tooth is missing, no allowance will be made for the service provided that tooth.
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.
325. Duplicate submission of previously processed service.
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 |