ACCESS DENTAL

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

FOR

Access Dental Plan, Inc.
P.O. Box 659005
Sacramento, CA 95865-9005
(916) 646-2130

www.AccessDental.com

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

This form is a summary of the dental services available to you as an Enrollee of Access Dental Plan, Inc. **Please keep these materials for your reference as they contain important information regarding the Plan and its operations.** Any questions you have regarding coverage on any of the following specific provisions may be directed to any Plan Member Services Representative or the telephone number listed in this booklet.

This Evidence of coverage ("EOC") states the terms and conditions of coverage under the Sacramento Geographic Managed Care Program. Prior to enrollment, an applicant has a right to view the EOC by contacting a Plan Member representative at 916-646-2130 or by email at Info@accessdental.com. The EOC should be read completely and carefully and if you require special dental care treatment, an applicant should carefully read those sections that may apply. If you require additional information about the benefits of the plan, you may contact a Member Representative at 916-646-2130 or send an e-mail to Info@accessdental.com. The Plan's Benefit Matrix is attached to the end of the EOC.

You may also visit our website at www.AccessDental.com to review your Evidence of Coverage, Benefit Schedule and a list of network providers.

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SECTION I. DEFINITIONS

A. "**ADULT**" means MEMBERS age 21 and over who will continue to be enrolled in Medi-Cal Managed Care Plan with a limited scope of benefits effective July 1, 2009.

B. "**BENEFITS AND COVERAGE**" means the dental health care services available under the Geographic Managed Care Program and dental provisions of the California Medi-Cal program.

C. "**DENTI-CAL**" means dental program or dental services as a Medi-Cal benefit.

D. "**DHCS**" is the abbreviation for the Department of Health Care Services.

E. "**ELECTIVE DENTISTRY**" or "**EXCLUSION**" means any dental procedure(s) or service(s) not available under the Geographic Managed Care Program and the dental provisions of the California Medi-Cal program.

F. "**EMERGENCY CARE**" means services required for alleviation of severe pain or bleeding and / or immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction, or death.

G. "**FRADS**" is the abbreviation for Federally Required Adult Dental Services. The services that are allowable as Federally Required Adult Dental Services (FRADS) under this definition are listed in Attachment D.

H. "**GMC**" is the abbreviation for Geographic Managed Care.

I. "**HCO**" is the abbreviation for Health Care Options.

J. "**LIMITATION**" means any provision other than an EXCLUSION which restricts coverage for the providing of dental health care services under the PLAN.

K. "**MEMBER**" means any presently enrolled Medi-Cal recipient who has completed a PLAN membership application and receives PLAN BENEFITS.

L. "**MEDI-CAL BENEFICIARY**" means all presently enrolled California Medi-Cal recipients who are eligible to participate in the PLAN pursuant to PLAN eligibility requirements.

M. "**PLAN**" means Access Dental Plan, Inc.

N. "**PRIMARY CARE DENTIST**" means a general or pediatric dentist that coordinates, supports and provides the delivery of dental care.

O. "**PROVIDER**" means a dentist providing general or specialty dental services under contract with the PLAN.

P. "**SERVICE AREA**" means the geographic area designated by the PLAN within which the PLAN shall provide BENEFITS AND COVERAGE.

SECTION II. ELIGIBILITY

Any eligible MEDI-CAL BENEFICIARY residing within Sacramento County is eligible to receive COVERAGE for dental services. You may visit the Denti-Cal and Medi-Cal websites for updated information at www.denti-cal.ca.gov and www.medi-cal.ca.gov. To receive COVERAGE, a MEDI-CAL BENEFICIARY should complete an Enrollment / Disenrollment form available through Health Care Options (HCO) who may be reached at 1-800-430-4263 or at the PLAN Provider offices. Once completed, the form should be returned to:

Health Care Options (HCO)
P. O. Box: 989009
West Sacramento, California 95798-9850

The Health Care Options Program has also added language lines and has changed the process for answering those lines. The language lines now include:

Argentinean	(800) 840-5032
Cambodian	(800) 430-5005
Cantonese	(800) 430-6006
English	(800) 430-4263
Farsi	(800) 840-5034
Hmong	(800) 430-2022
Laotian	(800) 430-4091
Russian	(800) 430-7007
Spanish	(800) 430-3003
Vietnamese	(800) 430-8008
TDD	(800) 430-7077

Eligibility under the PLAN will continue unless a MEMBER becomes ineligible for coverage under the California Medi-Cal program, disenrolls from the PLAN, moves out of the service area, or eligibility changes to a GMC ineligible aid category (see section IV).

A MEMBER may be entitled to continue to receive dental care by the PLAN even if he or she is no longer eligible because of an increase in income. The California Health and Human Services offers dental coverage through the Transitional Medi-Cal Coverage Program. To receive additional information about the transitional coverage and whether you would qualify, please contact the California Department of Health and Human Services at 1-800-880-5305, or visit the Denti-Cal and Medi-Cal websites at www.denti-cal.ca.gov and www.medi-cal.ca.gov.

SECTION III.
COMMENCEMENT OF COVERAGE

COVERAGE shall begin at 12:01 a.m. on the first day of the month for which the MEMBER'S name is added to the approved list of MEMBERS furnished by the Department of Health Care Services to the PLAN.
The term of membership will continue indefinitely unless this Contract expires, is terminated, or the MEMBER is disenrolled under the conditions described below.

SECTION IV.
TERMINATION / CANCELLATION OF BENEFITS

Termination or cancellation of PLAN COVERAGE shall take place immediately upon: the PLAN's receipt of notification that a MEMBER is ineligible to participate in the Medi-Cal Program, a MEMBER's change of residence to a location outside Sacramento County, or MEMBER is covered by Medi-Cal in an ineligible aid category, and **termination of PLAN COVERAGE by MEMBER.** Disenrollment (if appropriate) shall be effective within 15 to 45 days after receipt of a MEMBER's complete and executed disenrollment form by HCO. A PLAN disenrollment form is available at the PLAN office headquarters, any PLAN PROVIDER office, or by calling 1-800-430-4263. A MEMBER may voluntarily disenroll from the PLAN at any time and can enroll in another plan either through MEMBER's own choice or through default.

The PLAN shall not terminate or cancel COVERAGE to a MEMBER based upon the MEMBER's health status or requirements for health care services. Any MEMBER who alleges that an enrollment has been canceled because of the MEMBER's health status or requirements for health care services may request a review of cancellation by the Commissioner of the Department of Managed Health Care, at the 800 number referred to in Section XXV.

An individual whose PLAN benefits have been previously terminated or canceled and who is now an eligible MEDI-CAL BENEFICIARY may re-enroll in the PLAN. Refer to section II and III, respectively, of this Combined Evidence of Coverage and Disclosure form for eligibility and coverage.

A MEMBER will be disenrolled from the PLAN on the first day of the month following any of the following events:

1. a MEMBER seeks dental care on a fee-for-service basis from an Indian Health Service facility;
2. a MEMBER is receiving care under the Foster Care or Adoption Assistance Program or through the Child Protective Services;
3. a MEMBER has a complex medical condition, such as pregnancy, in need of an organ transplant, chronic renal condition, tested positive for HIV or AIDS, receiving treatment for cancer, requiring major surgery, receiving care for a complex neurological condition, or receiving sub-acute, acute, intermediate or skilled nursing care;
4. a MEMBER is enrolled in a Medi-Cal waiver program;
5. a MEMBER is participating in a Department of Health Care Services' Pilot Project;
6. a MEMBER was incorrectly assigned to the PLAN;
7. a MEMBER has moved outside the PLAN's approved service areas; and
8. a MEMBER is already receiving dental care through another dental plan or Medicare.

SECTION V.
PLAN-INITIATED DISENROLLMENT

The PLAN may recommend to DHCS the disenrollment of any MEMBER for cause. Except in cases of violent behavior or fraud, the PLAN shall make significant effort to resolve the problem with the MEMBER through avenues such as reassignment of PRIMARY CARE DENTIST or education before requesting a PLAN-initiated disenrollment. The PLAN will submit to DHCS a written request for disenrollment with supporting documentation based on the breakdown of the PLAN-MEMBER relationship. The PLAN may recommend to DHCS the disenrollment of a MEMBER because of, but not limited to, one of the reasons below:

1. Repeated and Unjustified Verbal Abuse
   MEMBER is repeatedly abusive to the PROVIDERS, ancillary or administrative staff, subcontractor staff or to other PLAN MEMBERS;

2. Unjustified Physical Abuse
   MEMBER physically assaults a PROVIDER or staff person, subcontractor staff person, or other MEMBER, or threatens another individual with a weapon on the PLAN's premises. In this instance, the PLAN or the PROVIDER will file a police report and file charges against the MEMBER;

3. Unjustified Disruptive Behavior
   MEMBER is disruptive to PLAN's operations in general;

4. Habitual Use of Non-Network Providers
   MEMBER habitually uses providers not affiliated with the PLAN for non-emergency services without required authorizations (causing PLAN to be subjected to repeated PROVIDER demands for payment for those services or other demonstrable degradation in PLAN's relations with community PROVIDERS);

5. Fraudulent Use of Medi-Cal Coverage
   MEMBER has allowed the fraudulent use of Medi-Cal coverage under the PLAN, which includes allowing others to use the MEMBER's PLAN Membership card to receive services from PROVIDERS; or

6. Unjustified Noncompliance with Prescribed Treatment
   A MEMBER's failure to follow prescribed treatment (including failure to keep established dental appointments) will not, in and of itself, be good cause for the approval by the DHCS of a PLAN-initiated disenrollment request unless the PLAN can demonstrate to DHCS that, as a result of the failure, the PLAN is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the PLAN and rate negotiations.

The PLAN-initiated disenrollment must be prior approved by DHCS. The PLAN will notify the MEMBER in writing about the PLAN's intent to disenroll the MEMBER for cause. The PLAN will allow a period of twenty (20) calendar days from the date of the receipt of the letter for the MEMBER to respond to a proposed action prior to disenrollment.

SECTION VI.
PREPAYMENT FEE, PERIODIC PAYMENTS AND OTHER CHARGES

There are no prepayment fees, periodic payments, co-payments, or other charges required from MEMBERS for COVERAGE under the PLAN.

SECTION VII.
LIABILITY OF MEMBER FOR PAYMENT

In the event the PLAN fails to pay the PROVIDER, the MEMBER shall not be liable to the PROVIDER for any sums owed by the PLAN. In the event the PLAN fails to pay any unauthorized, non-contracting providers, the MEMBER may be liable to the non-contracting provider for the cost of services. A MEMBER shall additionally be liable for the payment(s) to any contracting or non-contracting provider for the services not covered under the PLAN.

SECTION VIII.
PLAN BENEFITS AND COVERAGE

The PLAN agrees to provide COVERAGE to MEMBERS for all dental health care services available under the dental provisions of the California Medi-Cal program. MEMBERS under age 21 must obtain all Medi-Cal covered non-emergency dental services through the PLAN's PROVIDERS. **Most dental services for adults, age 21 and older, are no longer covered under Medi-Cal, as of July 1, 2009 and will not be covered by the PLAN. There are some exceptions, which are listed in detail in the following sections. The PLAN will continue to cover adult dental services for certain MEMBERS classified with the exemptions outlined in Section IX of this document.**

A current list of services is set forth in the Benefits Schedule accompanying this Combined Evidence of Coverage and Disclosure Form as Attachment "A" for Members under age 21 and Attachment "D" for adult Members. These schedules establish the dental care and services which are available to MEMBERS without charge.

To obtain benefits under the PLAN, a MEMBER shall contact his or her PROVIDER for appointment scheduling. MEMBERS are not required to provide or complete claims forms for the receipt of COVERAGE under the PLAN.

The PLAN does not offer medical or non-medical transportation to or from a dental office. The PLAN's Member Representative will assist you by providing information about available public transportation to and from a dental office. If you would like information about public transportation options, please contact a Member Representative at 916-646-2130.

SECTION IX.
EXEMPTIONS TO ELIMINATED ADULT DENTAL BENEFITS

The following are exemptions to the eliminated adult dental benefits. In the following circumstances, Medi-Cal Dental providers may continue to provide services after July 1, and be reimbursed by Medi-Cal for those services:

- Medical and surgical services provided by a doctor or dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state.
  - Federal law requires the provision of these services. The services that are allowable as Federally Required Adult Dental Services (FRADS) under this definition are listed in Attachment D.
- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy.
  - This includes 60 days of postpartum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed under Table 1 (Federally Required Adult Dental Services) or Table 2 (Allowable Procedure Codes for Pregnant Women), in Attachment D.
- ADULT beneficiaries (age 21 and older) whose course of treatment began prior to July 1, 2009 and is scheduled to continue on or after July 1, 2009.
  - In these cases, the beneficiary must have been seen by the provider and the necessary course of treatment was evident prior to July 1, 2009. Note, this relates to a specified course of treatment with a completion date (e.g., to prepare a patient for dentures, and fabricate and deliver the dentures). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to the completion of treatment that was determined to be necessary before the benefits were eliminated.** This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) beyond July 1, 2009.
- Beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21 years of age (continuing services for EPSDT recipients) [Note: With the exception of orthodontic services which must be completed by the beneficiary's 21st birthday.]
  - In these cases, the beneficiary must have been seen by the provider and the necessary treatment was evident prior to his/her 21st birthday. Note, this relates to a specified course of treatment (e.g., to perform a root canal or complete a crown). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to completion of treatment that was determined to be necessary before the person became ineligible for that service due to reaching age 21.** This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) after the person turns 21.
- Beneficiaries receiving long-term care in a Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF), as defined in the *Health and Safety Code* (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k) are exempt from the change in adult dental services on July 1, 2009.

Beneficiaries residing in ICF-Developmentally Disabled (DD), ICF-Developmentally Disable Habilitative (DDH) or ICF-Developmentally Disable Nursing (DDN) are also exempt from the change in adult dental services on July 1, 2009.

- The facility definitions are available on the California Department of Public Health Website at http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx. Providers may confirm the licensing of a facility from this Web page.
- Dental Services do not have to be provided in the facility to be payable. Providers are reminded to follow the existing prior authorization and documentation requirements.
- If a provider receives a denial on a claim for a beneficiary who resides in a licensed SNF or ICF, the provider can submit a Claim Inquiry Form (CIF) including the facility name and address and have the claim reprocessed. If the services were denied on a prior authorization request, the provider can submit the prior authorization notice and request re-evaluation.

- Dental Service Precedent to a Covered Medical Service.
  - Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under FRADS listed in Table 1 of Attachment D. A precedent dental service that is not on the list of FRADS will be evaluated and adjudicated on a case by case basis.

An adult dental service may be reimbursable if any one of the above exceptions is met.

SECTION X.
LIMITATIONS AND EXCLUSIONS

Members Under Age 21

Limitations:
- Full upper and/or lower dentures are not to exceed one each in any five (5) year period
- Cleaning (prophylaxis) once every six (6) months
- Fluoride Varnish under (6) six years of age, up to three times in a 12-month period
- Relines limited to one per appliance per twelve (12) months
- Full mouth X-rays - once every three (3) years
- Posterior laboratory processed crown not a benefit for adults 21 years of age and older except when posterior tooth is used as an abutment for any fixed or removable prosthesis with cast clasps and rests and meets Denti-Cal Criteria.

Exclusions:
- Braces, except in the treatment of malocclusion for persons under the age of 21 years, or cleft palate deformities under the case management of California Children Services Program
- Treatment of incipient or non-active cavities in adults
- Cosmetic procedures
- Removable partial dentures, except when necessary for balance of a complete artificial denture
- Extraction of healthy teeth, except for: serial extractions required to minimize problems with the bite; teeth that interfere with denture or bridge construction; conditions perceptible through x-rays but which fail to elicit symptoms
- Pulp caps
- Fixed bridges, except when necessary for obtaining employment; medical conditions which preclude use of removable dentures
- Pedodontist referrals are not available for children 11 years old and older

Adult Members Not Otherwise Exempt

Limitations:
- Limited dental services for the relief of pain and infection such as tooth removal

Exclusions:
- Comprehensive oral evaluations for new or established patients
- Prophylaxis and fluoride treatments
- Amalgam and resin based composite restorations
- Prefabricated and laboratory processed crowns
- Endodontic treatment

- Periodontal procedures including scaling and root planing
- Removable prosthodontic treatment including complete and partial dentures, relines and tissue conditioning and adjustment and repairs
- Fixed prosthodontic procedures
- Implant procedures

SECTION XI.
EMERGENCY CARE

EMERGENCY CARE is available to MEMBERS twenty-four (24) hours a day. EMERGENCY CARE is defined as services needed to alleviate severe pain, swelling, or bleeding, associated with a sudden serious and unexpected illness or injury. During regular PROVIDER office hours, MEMBERS may obtain care by contacting their PRIMARY CARE DENTIST for EMERGENCY treatment. After business hours, MEMBERS should contact their PRIMARY CARE DENTIST or **MEMBERS may contact a twenty-four (24) hour answering service at (916) 646-2130.** The on-call operator will get information from the MEMBER regarding the EMERGENCY and relay the information to the on-call PROVIDER. This PROVIDER will then telephone the MEMBER within one (1) hour from the time of the MEMBER's call. The on-call PROVIDER will assess the EMERGENCY and in the event emergency dental services are required, a PLAN PROVIDER will meet the MEMBER at the closest available PROVIDER facility for treatment.

If a MEMBER requires EMERGENCY CARE when outside the SERVICE AREA, (the geographic area designated by the PLAN within which the PLAN shall provide BENEFITS AND COVERAGE) a MEMBER may seek treatment from the nearest available dentist or emergency room as the circumstances dictate.

Any Provider outside the PLAN's SERVICE AREA may treat your emergency and will be reimbursed without prior authorization.

Care that the PLAN determines not to meet the definition of EMERGENCY CARE will not be covered. Non-PLAN PROVIDERS may require the MEMBER to make immediate full payment for services. If the MEMBER has to pay the full bill, the PLAN will reimburse the MEMBER for services that meet the definition of EMERGENCY CARE as defined above. If the MEMBER pays a bill, a copy of the bill should be submitted to the following address within 90 days from the date of treatment:

Access Dental Plan
Attention: Claims Department
P.O. BOX: 659005
Sacramento, CA 95865-9005

Once the MEMBER has received EMERGENCY CARE, the MEMBER must contact his or her PRIMARY CARE DENTIST (if the MEMBER's own PRIMARY CARE DENTIST did not perform the EMERGENCY dental care) for follow-up care. The MEMBER will receive all follow-up care from his or her own PRIMARY CARE DENTIST.

SECTION XII.
CHOICE OF PROVIDERS

MEMBERS may select a dentist from the attached list of PRIMARY CARE PROVIDERS in the Access Dental Network. The MEMBERS should indicate their choice of PROVIDER on the Enrollment form. A MEMBER may transfer to another PROVIDER by contacting the primary PLAN office by telephone at (916) 646-2130 and requesting such a transfer. The transfer to the new provider will be effective on the first day of the following month. All requests for transfer are subject to the availability of the chosen PROVIDER. Should any MEMBER fail to select a PROVIDER, the PLAN will assign the MEMBER to an available PROVIDER closest to their residence. To receive information and assistance, MEMBERS should contact a MEMBER Services Representative by calling the telephone number listed in this brochure.

PRIMARY CARE DENTISTS are required to provide covered services to MEMBERS during normal working hours and during such other hours as may be necessary to keep MEMBERS appointment schedules on a current basis.

Appointments for routine, preventive care and specialist consultation shall not exceed three weeks from the date of the request for an appointment.

Wait time in the PRIMARY CARE DENTIST’s office shall not exceed 30 minutes.

The PLAN may be unable to assign MEMBERS to their choice of PRIMARY CARE DENTIST for one of the following reasons:

- The PRIMARY CARE DENTIST is not currently accepting new patients. (This is probably a temporary situation and the MEMBER may transfer to this PRIMARY CARE DENTIST at a later date.)
- If the PRIMARY CARE DENTIST reaches a maximum ratio of assigned MEMBERS.

Except for EMERGENCY CARE, any services and supplies obtained from any PROVIDER than the MEMBER's PRIMARY CARE DENTIST without an approved referral will not be paid for under the PLAN.

If you desire, you may receive general dental care at the Sacramento Native American Health Center or a Federal Qualified Health Center, which provides dental care. If you would like information regarding receiving dental treatment at the Sacramento Native American Health Center or a Federal Qualified Health Center, please contact the PLAN's Member Representative.

Please note that regardless of the availability of Indian Health Service facilities, MEMBERs who are Native American may continue to receive treatment at his or her current dental provider.

SECTION XIII.
SECOND OPINIONS

MEMBERS or PRIMARY CARE DENTISTS may request a second opinion for Covered Services by contacting the PLAN. The PLAN shall provide or authorize a second opinion by an appropriately qualified dental provider. The reasons for a second opinion shall include, but are not limited to the following reasons: the MEMBER questions the reasonableness or necessity of the recommended procedures; 2) if the MEMBER questions the diagnosis or PLAN of care for a condition that threatens loss of life, substantial impairment, including a serious chronic condition; 3) if the clinical indications are not clear, the PRIMARY CARE PROVIDER is unable to diagnose the condition or the diagnosis is unclear due to conflicting test results and the MEMBER requests additional diagnosis; 4) if the treatment PLAN in progress is not improving the dental condition of the MEMBER within an appropriate period of time given the diagnosis and the MEMBER requests a second opinion regarding the diagnosis or continuance of treatment; 5) if the MEMBER has attempted to follow the PLAN of care or consulted with the initial PRIMARY CARE PROVIDER concerning serious concerns about the diagnosis or PLAN of care.

The PLAN shall review the reasons for the request of a second opinion and provide an authorization or a denial in an expeditious manner. The second opinion will be rendered within 72-hours from the PLAN's receipt of request where the MEMBER's condition poses imminent and serious threat to the MEMBER's life.

MEMBERS interested in obtaining the timeline for authorizing second dental opinions can contact the PLAN at

Access Dental Plan, Inc.
Referrals Department
P.O. Box: 659005
Sacramento, CA 95865-9005
800-270-6743 ext. 6012

The cost of obtaining the second opinion will be paid by the PLAN.

SECTION XIV.
REFERRALS TO SPECIALIST

The MEMBER must first visit his or her PRIMARY CARE DENTIST for evaluation of MEMBER's case. Once the PRIMARY CARE DENTIST determines that the MEMBER requires the care of a specialist, the PRIMARY CARE DENTIST will determine if the MEMBER needs an emergency referral or a routine referral. The PLAN processes emergency referrals immediately by calling a specialist to coordinate the scheduling of an appointment for the MEMBER with the specialist. Routine referrals are processed within five (5) business days from the date the request is received in our office and referrals affecting care where the MEMBER faces an imminent and serious threat to MEMBER's health within 72-hour or less of the receipt of the necessary documentation. Copies of authorizations for regular referrals are sent to the MEMBER, the specialist and the MEMBER's PRIMARY CARE DENTIST. The PLAN reserves the right to determine the facility and PLAN provider from which covered services requiring specialty care are obtained.

The PLAN encourages MEMBERS to contact their PRIMARY CARE PROVIDERS to schedule a follow-up appointment after the completion of the treatment by the specialist provider.

Decisions to approve, modify, or deny, based on dental necessity, prior to or concurrent with the provisions of dental shall be made by the PLAN in a timely fashion appropriate for the nature of the MEMBER's condition, not to exceed five (5) business days from the PLAN's receipt of the information reasonably necessary and requested by the PLAN to make the determination.

When the MEMBER's condition is such that the MEMBER faces an imminent and serious threat to his or her dental health including, but not limited to, the loss of major dental function, or if waiting in accordance with the timeframe noted

in the above paragraph could jeopardize the MEMBER's ability to regain maximum function, the PLAN's decision to approve, modify, or deny referral requests by a MEMBER's PRIMARY CARE DENTIST prior to, or concurrent with, the provision of dental care services to a MEMBER shall be made in a timely fashion appropriate for the nature of the MEMBER's condition, not to exceed 72 hours after the PLAN's receipt of the information reasonably necessary and requested by the PLAN to make the determination.

The PLAN shall initially notify by telephone or facsimile the MEMBER's PRIMARY CARE DENTIST requesting a referral of its decision to approve, modify, or deny requests for referral authorization within 24 hours of the PLAN's decision. The PLAN shall also immediately inform the MEMBER's PRIMARY CARE DENTIST in writing its decision to approve, modify or deny the requested referral. If the requested referral is approved, the PLAN shall specify in the notice the specific dental care service approved. If the requested referral is denied, delayed or modified, the notice shall include a clear and concise explanation of the reasons for the decisions, the criteria or guideline used, and the clinical reasons for the decisions regarding medical necessity. Additionally, the notice shall include the name and direct telephone number of who made the decision at the PLAN.

If the PLAN cannot make a decision to approve, modify, or deny the request for authorization within the 72 hours or 5 business day timeframes because the PLAN is not in receipt of all the information reasonably necessary and requested, or because the PLAN requires consultation by an expert reviewer, or because the PLAN asked for an additional examination or test be performed upon the MEMBER, the PLAN shall immediately upon the expiration of the 72 hours or 5 business day time frames noted above, or as soon as the PLAN becomes aware it will not meet the 72 hours or 5 business day time frames, whichever occurs first, notify the referring PRIMARY CARE DENTIST and the MEMBER, in writing, that the PLAN can not make a decision within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Once the PLAN receives all the information reasonably necessary and requested, the PLAN shall approve, modify, or deny the request for authorization in a timely fashion appropriate for the nature of the MEMBER's condition, not to exceed 72 hours or 5 business days, as the case may be. Further information regarding the processes, criteria and procedures that the PLAN uses to authorize, modify, or deny dental services under the benefits provided by the PLAN are available to the MEMBER, PRIMARY CARE DENTISTS, and the public upon request.

SECTION XV.
HOW PROVIDERS ARE COMPENSATED

The PLAN compensates its PROVIDERS in a variety of ways. Generally, PROVIDERS are paid on what is called a "capitated basis." This means that the PLAN pays a per-MEMBER-per-month fee to the PROVIDERS who provide services to the PLAN's MEMBERS. Some PROVIDERS are compensated based on a combination of monthly capitation and significant fee-for-service supplemental payments from the PLAN. Some PROVIDERS are paid incentive payments. The PLAN's PROVIDERS are always required by the PLAN to provide services in a quality manner in accordance with detailed regulatory and contractual requirements. These requirements help reduce overall costs by providing quality care which emphasizes preventive health care access and utilization of effective treatment methods.

A MEMBER may obtain additional information regarding the PROVIDERS' compensation by contacting the PLAN at (916) 646-2130 or the MEMBER's PROVIDER.

SECTION XVI.
CALIFORNIA CHILDREN SERVICES

California Children Services (CCS) is a state program administered through local county offices. The program treats children under 21 years of age with certain physical limitations and diseases. The program is paid for by California taxpayers and offers medical care to children whose families cannot afford all or part of the needed care. If a MEMBER has a CCS eligible condition, MEMBER needs to apply to CCS for services under the CCS program. MEMBERS who may be eligible for dental services through the CCS program include those who have been accepted for and are authorized to receive orthodontic services for medically handicapping malocclusion by a CCS-paneled orthodontist, as well as other clients with CCS-eligible conditions such as cleft lip and/or palate, congenital and/or acquired oral and craniofacial anomalies, complex congenital heart disease, seizure disorder, immune deficiencies, cerebral palsy, hemophilia and other blood dyscrasia, malignant neoplasms, including leukemia, rheumatoid arthritis, nephrosis, cystic fibrosis, and organ transplants.

The PLAN shall continue to provide all dentally necessary covered services and case management services for MEMBERS referred to CCS until eligibility for the CCS program is established. Once eligibility for the CCS program is established for a MEMBER, the PLAN shall continue to provide Primary Dental Care and other dentally covered services unrelated to the CCS-eligible condition and will ensure the coordination of services between its Primary Care Dentists, the CCS-specialty providers, and the local CCS Program.

For any further information concerning the CCS program, please contact your local CCS Chapter at (916) 875-9900. If you suspect that you have a CCS condition, it is recommended that you also contact your primary care physician.

SECTION XVII.
CONTINUITY OF CARE

Upon request of a current or newly covered MEMBER, PLAN must provide for the completion of covered services for treatment of certain specified conditions if (a) the services were being provided by a terminated provider at the time of termination of the provider's contract, or (b) the covered services were being provided by a nonparticipating provider to a newly covered MEMBER at the time his or her coverage became effective. MEMBERS are entitled to continuation of services from such providers for the following circumstances and timeframes:

Acute Conditions: The duration of an acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).

Newborn Children between Birth and Age 36 Months: PLAN shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the provider's contract or 12 months from the effective date of coverage for a newly covered MEMBER.

Surgery or Other Procedure: Performance of surgery or other procedure authorized by PLAN as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current MEMBERS or 180 days from the effective date of coverage for newly covered MEMBER.
PLAN is not required to provide benefits that are not otherwise covered under the terms and conditions of the subscriber contract. This policy does not apply to a newly covered MEMBER covered under an individual subscriber agreement.

MEMBERS may request continuation of care by calling PLAN's Customer Service Department at (916) 646-2130 during normal business hours, or by sending a written request to the PLAN. PLAN may obtain copies of the MEMBER's dental record from the MEMBER's provider in order to evaluate the request.

The Dental Director will determine if the MEMBER is eligible for continuation of care under this policy and the California laws and regulations. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider: whether one of the circumstances described above exists; whether the requested services are covered by PLAN; and the potential clinical effect that a change of providers would have on the MEMBER's treatment.

The PLAN shall provide the MEMBER with the Dental Director's decision in writing within 5 business days of the receipt of the request and the copy of the MEMBER's dental record or in a sooner timely manner appropriate for the MEMBER's clinical condition. The written notice shall inform the MEMBER how to file a grievance in the event the MEMBER is dissatisfied with the decision.

PLAN requires the terminated or nonparticipating provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. PLAN is not required to continue the services a provider is providing to a MEMBER if the provider does not agree to comply or does not comply with these contractual terms and conditions. Unless PLAN and provider agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by PLAN for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. PLAN is not required to continue the services a provider is providing to a MEMBER if the provider does not accept the payment rates provided for in this paragraph.

MEMBERS may request a copy the PLAN's Continuation of Care Policy by calling the PLAN's Customer Service Department at (916) 646-2130.

SECTION XVIII.
FACILITIES

A list of the PLAN's current PROVIDERS, PROVIDER facilities and PROVIDER hours of operations is available at www.AccessDental.com.

SECTION XIX.
INTERPRETIVE SERVICES

By contacting a PLAN MEMBER Service Representative at (916) 646-2130, MEMBERS have access to interpreters who can interpret from English into as many as 140 languages.

An appropriate MEMBER Service Representatives will assist each prospective MEMBER or current MEMBER in obtaining covered services from PLAN PROVIDERS, maintaining appropriate interpretative services, or arrange for a PLAN interpreter to assist MEMBERS in obtaining covered services at an appropriate PLAN PROVIDER office.

SECTION XX.
WORKERS COMPENSATION

If a MEMBER receives services which are recoverable by adjudication or settlement, under any worker's compensation law, employer liability law, or occupational disease law, the PLAN agrees to advance the services and benefits covered. The PLAN will not make a claim against or otherwise obtain reimbursement for such recovery. The PLAN will notify the Department of Health Care Services within 10 days of discovery an action by a MEMBER involving the tort or worker's compensation liability of a third party that may result in recovery of funds to which the Department has lien rights.

SECTION XXI.
MEMBERS RESPONSIBILITY AND DENTAL HEALTH MAINTENANCE

A MEMBER should take responsibility for knowing and understanding the rules and regulations of the PLAN and to abide by them in the interest of quality dental care. The PLAN encourages MEMBER's to actively participate in preventive health care programs run through the schools. All MEMBERS should learn about their dental condition(s) and should follow prescribed treatment plans.

The MEMBER should contact his or her primary care dentist to make a dental appointment. On the day of the appointment, the MEMBER should arrive at the office five to ten minutes early in order to fill out the necessary paperwork. If the MEMBER cannot keep the appointment, the MEMBER is responsible for calling the dentist and rescheduling at least 24 hours in advance of the appointment.

Each MEMBER has the opportunity to work towards a healthy dental routine by requesting individual counseling from the Primary Care Dentist, adopting positive lifestyle choices, such as brushing with a fluoride toothpaste, flossing, checkups, good diet, avoiding tobacco, not biting hard food, or not opening containers with teeth. Also MEMBERS are encouraged to attend classes held throughout the community addressing health education and promotion, and to read health education materials available at each Primary Care Dentist's office.

MEMBERS are also encouraged to visit the PLAN's website at www.AccessDental.com to obtain educational information related to oral health or contact the PLAN at (916) 646-2130 to receive a copy.

SECTION XXII.
PROMOTION OF A HEALTHY LIFESTYLE

The PLAN will ensure that the network of Primary Care Dentists perform preventive services, encouraging providers to conduct MEMBER education, and providing health education materials at each Primary Care Dentist's office.

SECTION XXIII.
COMPLAINTS AND DISPUTES

Any information, dispute or complaint should be directed to the PLAN at:

Access Dental Plan, Inc.
Complaint / Grievance Department
P.O. BOX: 659005
Sacramento, CA 95865-9005

Grievance Department: (916) 563-6013
Or (916) 646-2130

Any information, dispute or complaint may furthermore be directed to any PLAN PROVIDER office during regular business hours.

SECTION XXIV.
GRIEVANCE PROCEDURES

MEMBERS are encouraged to contact the PLAN or any PLAN PROVIDER office concerning any problem they may have experienced with any aspect of the PLAN or its PROVIDERS. The PLAN has a MEMBER grievance procedure to handle complaints or grievances by MEMBERS of the PLAN. MEMBER complaints or grievances may be made in person at the PLAN OFFICE, 8890 Cal Center Drive, Sacramento, CA 95826 from 9:00 a.m. to 6:00 p.m. Monday through Friday (holidays excluded), by telephone at Grievances Department at (916) 563-6013 or (916) 646-2130, or in writing to Member Services at the above address, or on the PLAN's website at www.accessdental.com A grievance form is attached to this Combined Evidence of Coverage and Disclosure Form as Attachment "B" and is available at the PLAN office or any PLAN PROVIDER office. Staff will be available at the PLAN office or any PLAN PROVIDER office to assist MEMBERS in completion of this form. MEMBERS will receive written notification of receipt of their complaint/grievance within five (5) days. This notice will include the PLAN's contact person for their complaint. Additionally, the MEMBER will receive a response within thirty (30) days as to resolution of their grievance. MEMBERS have the right to file a grievance if MEMBERS believe their linguistic needs have not been met. MEMBERS may also file a Request for Assistance to the Department of Managed Health Care after participating in the PLAN's grievance procedure for 30 days.

The PLAN will expedite the review of grievances for cases involving an imminent and serious threat to the health of the MEMBER, including but not limited to, severe pain, potential loss of life, or major bodily function. In cases that require expedited review, the MEMBER has the right to file a Request for Assistance with the Department of Managed Health Care immediately and without having to participate in the PLAN's 30 days grievance procedures first. The PLAN shall immediately inform the MEMBERS in writing of their right to notify the Department of Managed Health Care of the grievance. The PLAN will also provide MEMBERS and the Department with a written statement of the disposition of pending status of the grievance no later than (3) days from the receipt of the grievance.

For grievances involving the delay, denial, or modification of dental care services, the PLAN's response will describe the criteria used by the PLAN and the clinical reasons for its decision, including all criteria and reasons related to dental necessity. In the event that the PLAN issues a decision delaying, denying, or modifying the dental services based on whole or part on a finding that the proposed services are not a covered benefit under the MEMBER's contract, the PLAN will then clearly specify the decision the provisions in the contract that exclude the coverage.

SECTION XXV.
APPEALS

MEMBERS are encouraged to submit appeals to the PLAN within 45 days from the date of the resolution of the grievance. MEMBERS will be informed in writing of the disposition of the appeal within 30 days of when the appeal request was received in writing. MEMBERS may also appeal grievance decisions by requesting a Fair Hearing from the Department of Social Services by contacting (800) 952-5253. The PLAN will provide annual notification to MEMBERS concerning its grievance procedures as well as periodic notification to MEMBERS of all changes in the PLAN.

DHCS - Ombudsman

The California Department of Health Care Services (DHCS) is responsible for monitoring contractual compliance of all managed care plans who serve Medi-Cal beneficiaries. DHCS has established an Ombudsman Unit with a toll-free telephone number (1-888-452-8609) to receive complaints regarding Medi-Cal managed care plans.

SECTION XXVI.
FAIR HEARING

MEMBER has the right to the Medi-Cal fair hearing process regardless of whether or not a complaint or grievance has been submitted or if the complaint or grievance has been resolved, when a health care service requested by the MEMBER or PROVIDER has not been provided. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number is 1-800-952-5253. Or the MEMBER may write to:

Office of the Chief Administrative Law Judge
State Department of Social Service
c/o The Department of Health Care Services
P.O. Box: 13189
Sacramento, California 95813-3189

DMHC - 800 NUMBER

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-800-707-6453) and use your health plan' s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

SECTION XXVII.
PUBLIC POLICY PARTICIPATION

The PLAN seeks interested MEMBERS to participate in the Public Policy Committee for the purposes of establishing the Public Policy of the PLAN. This committee consists of three (3) PLAN MEMBERS, one (1) PLAN PROVIDER, the PLAN's Dental Director, and the PLAN's Administrator. PLAN MEMBERS and the PLAN PROVIDER shall each serve a three (3) year term while the PLAN's Administrator and Dental Director will be permanent committee members. The PLAN will reimburse MEMBERS $100.00 per meeting for their participation.

The Public Policy Committee meets quarterly to review the PLAN's performance and future direction of PLAN operations. Information regarding PLAN operations, grievance log reports, financial operations and the like will be made available to PLAN MEMBERS for review and comment. Recommendations and reports from the Public Policy Committee will be made to the PLAN's Board of Directors at the next regularly scheduled Board meeting. Receipt of the recommendations and any reports from the Public Policy Committee shall be considered by the Board of Directors and duly noted in the Board's minutes.

Membership in the Public Policy Committee is voluntary, and will be determined by the entire Public Policy Committee with special consideration being made to the ethnicity, geographic location and economic status of the MEMBER applicants. A Public Policy Committee membership application is attached to this Combined Evidence of Coverage and Disclosure Form as **Attachment "C".** The PLAN will also annually mail applications to all MEMBERS for membership on the Public Policy Committee as positions on the committee become available.

SECTION XXVIII.
ORGAN DONATION

The donation of organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. Any individual who is at least 18 years of age, or an individual who is between 15 and 18 years of age (only upon the written consent of a parent or guardian), has the choice of making an organ donation.

An organ donation may be made only by the following:

1) A document of donation signed by donor.
2) A document of donation signed by another individual and by two witnesses, all of whom signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.
3) A document of donation orally made by a donor by means of tape recording in his or her own voice.

4) If a document of donation is attached to or imprinted on a donor's motor vehicle driver's license, the document of donation shall comply with the above-mentioned criteria. Revocation, suspension, expiration, or cancellation of the license does not invalidate the organ donation.

5) A document of donation may designate a particular physician or surgeon to carry out the appropriate procedures.

SECTION XXIX.
MEMBER CONFIDENTIALITY

Except as permitted by law, MEMBER information is not released without your or your authorized representative's consent. MEMBER-identifiable information is shared only with our consent or as otherwise permitted by law. The PLAN maintains policies regarding the confidentiality of MEMBER-identifiable information, including policies related to access to dental records, protection of personal health information in all settings, and the use of data for quality measurement. We may collect, use, and share medical information when Medically Necessary or for other purposes as permitted by law (such as for quality review and measurement and research.)

All of the PLAN's employees and PROVIDERS are required to maintain the confidentiality of MEMBER information. This obligation is addressed in policies, procedures, and confidentiality agreements. All PROVIDERS with whom we contract are subject to our confidentiality requirements. In accordance with applicable law, you have the right to review your own medical information and you have the right to authorize the release of this information to others.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED UPON REQUEST. To request a copy, please call our MEMBER Services Department.

SECTION XXX.
ARBITRATION

Should any dispute arise over the terms of this Agreement or administration thereof (except for claims of medical malpractice), which cannot be resolved to the satisfaction of both parties, either party may submit the dispute to binding arbitration. Under binding arbitration, both parties give up their rights to have the dispute decided by jury in a court of law. Either party may refer the dispute to the American Arbitration Association for resolution.

Binding arbitration is the final process for resolution of any dispute or controversy between a MEMBER or personal representative of the MEMBER, as the case may be, and the PLAN over the services provided to the MEMBER under this Agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this Agreement. MEMBER agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association ("AAA").

Each and every disagreement, dispute or controversy, which remains unresolved concerning the construction, interpretation, performance or breach of this Agreement, or the provisions of Covered Services under this Agreement, arising between a MEMBER or eligible dependent or personal representative of such persons, as the case may be, and the PLAN, its employees or PLAN provider or their medical groups, partners, agents or employees, shall be submitted to binding arbitration in accordance with this Section whether such dispute involves a claim in tort, contract or otherwise. This Section does not include disputes involving medical malpractice. It does include any act or omission which occurs during the term of this Agreement but which may give rise to a claim after the termination of this Agreement.

The MEMBER seeking binding arbitration shall send a written notice to the PLAN at the PLAN's address. The notice shall contain a demand for binding arbitration and a statement describing the nature of the dispute, including the specific issue(s), involved the amount involved, the remedies sought and a declaration that the party seeking binding arbitration has previously attempted to resolve the dispute with the PLAN. For further assistance, the MEMBER may also write the AAA at 3055 Wilshire Blvd., 7th Floor, Los Angeles, CA 90010-1108, or telephone (213) 383-6515.

In the case of extreme economic hardship, a MEMBER may request from the PLAN information on how to obtain an application for full or partial assumption of the MEMBER's share of fees and expenses incurred by the MEMBER in connection with the arbitration proceedings.

For all claims or disputes for which the total amount claimed is $200,000.00 or less, the parties shall select a single neutral arbitrator who shall have no jurisdiction to award more than $200,000.00. This provision is not subject to waiver, except nothing in this Section shall prevent the parties from mutually agreeing, in writing, after a case or dispute has arisen and a request for arbitration has been submitted, to use a tripartite arbitration panel which includes two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The agreement shall clearly indicate, in boldface type, that **"A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes**

for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less be adjudicated by a single neutral arbitrator." If the parties agree to waive the requirement to use a single neutral arbitrator, the enrollee or subscriber shall have three business days to rescind the agreement. If the agreement is also signed by counsel of the enrollee or subscriber, the agreement shall be binding and may not be rescinded. If the parties are unable to agree on the selection of a neutral arbitrator, the PLAN shall use the method provided in section 1281.6 of the Code of Civil Procedure to select the arbitrator.

The parties agree that the arbitrator(s) shall issue a written opinion, and the award of the arbitrator shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The findings of the arbitrator and the award of the arbitrator issued thereon shall be governed by the applicable state and federal statutory and case law. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator(s). The decision shall be signed by the arbitrator(s) in order to be effective.

The declaration of a court or other tribunal of competent jurisdiction that any portion of this Agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable. The arbitrator(s) shall make the necessary arrangements for the services of an interpreter upon the request of any party, which party shall assume the cost of such services. The arbitration shall take place in Sacramento, California, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the American Arbitration Association. The expenses of the arbitrator(s) shall be shared equally by the parties.

BENEFITS SCHEDULE FOR MEMBERS UNDER THE AGE OF 21
Health Care Services

Procedure Number

9010 Complete examination, initial episode of treatment only
9015 Examination periodic (annual)
9020 Office visit during regular office hours for treatment and/or observation of teeth or support structures
9030 Professional visit after regular office hours, or to bedside
9035 Hospital care
9040 Specialist consultation
9045 Pit and Fissure Dental Sealants for Permanent First Molars, to age eight (8)
9046 Pit and Fissure Dental Sealants for Permanent Second Molars, to age fourteen (14)
9047 Pit and Fissure Dental Sealants for beneficiaries to age twenty-one (21)
9049 Prophylaxis-beneficiaries through age 12
9050 Prophylaxis-beneficiaries age 13 years and older
9061 Prophylaxis, including topical application of fluoride-beneficiaries ages 6 through 17 years of age
Topical Fluoride Varnish: Therapeutic application for moderate to high caries risk patients-is a Medi-Cal benefit for children younger than (6) six years of age-D1206
9080 Emergency treatment, palliative
9110 Intraoral periapical, single, first film
9111 Intraoral periapical, each additional film
9112 Intraoral, complete series consisting of at least 14 periapical films plus bite-wings
9113 Intraoral, occlusal, each film
9114 Extraoral single, head or lateral jaw
9115 Extraoral each additional head or lateral jaw
9116 Bite-wing, two films
9117 Bite-wing, four films
9118 Bite-wings, anterior, one film
9119 Photograph or slide, first
9120 Photograph or slide, each additional (maximum five)
9125 Panographic-type film, single film
9150 Biopsy of oral tissue
9160 Gross and microscopic histopathological report

ORAL SURGERY (9200-9299)

9200 Removal of erupted tooth, uncomplicated, first tooth
9201 Removal of erupted tooth, uncomplicated, each additional tooth
9202 Removal of erupted tooth, surgical
9203 Removal of root or root tip, completely covered by bone
9204 Removal of root or root tip not completely covered by bone
9220 Postoperative visit, complications (e.g. osteitis)
9230 Removal o f impacted tooth-soft tissue
9231 Removal of impacted tooth-partial bony
9232 Removal of impacted tooth-complete bony
9250 Alveoplasty per quadrant, edentulous
9252 Alveoplasty per quadrant, in conjunction with extractions
9255 Vestibuloplasty, submucosal resection (not to include grafts)
9256 Alveoplasty with ridge extension secondary epithelialization (per arch)
9257 Removal of palatal exostosis (torus)
9258 Removal of mandibular exostosis (torus)-per quadrant
9259 Excision of hyperplastic tissue-(per arch)
9260 Incision and drainage of abscess, intraoral
9261 Incision and drainage of abscess, extraoral
9262 Excision pericoronal gingiva, operculectomy
9263 Sialolithotomy-intraoral
9264 Sialolithotomy-extraoral
9265 Closure of salivary fistula
9266 Dilation of salivary duct
9267 Reduction of tuberosity, unilateral
9269 Excision of benign tumor, up to 1.25 cm
9270 Excision of benign tumor, larger than 1.25 cm
9271 Excision of malignant tumor
9273 Reimplantation and/or stabilization of accidentally avulsed or displaced permanent teeth and/or alveolus
9275 Transplantation of tooth or tooth bud
9276 Removal of foreign body from bone-independent procedure
9277 Radical resection of bone for tumor with bone graft
9278 Maxillary sinusotomy for removal of tooth fragment or foreign body
9279 Oralantral fistula closure
9280 Excision of cyst, up to 1.25 cm
9281 Excision of cyst over 1.25 cm
9282 Sequestrectomy
9285 Condylectomy of mandible, unilateral
9289 Menisectomy of temporomandibular join, unilateral
9290 Excision of foreign body, soft tissue
9291 Frenectomy, or frenotomy, separate procedure
9292 Suture of soft tissue wound or injury
9294 Injection of sclerosing agent into temporomandibular joint
9295 Injection of Trigeminal nerve branches for destruction
9296 Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissue

Procedure Number

9297 Surgical exposure of impacted or unerupted tooth to aid eruption, partial bony
9298 Surgical exposure of impacted or unerupted tooth to aid eruption, complete bony
9299 Unlisted surgical service or procedure

DRUGS AND ANESTHESIA
(9300-9449)

9300 Therapeutic drug injection
9301 Conscious sedation relative analgesia, Nitrous oxide (N2O), per visit
9400 General anesthesia

PERIODONTICS
(9450-9499)

9451 Emergency treatment: (periodontal abscess, acute periodonitis, etc.)
9452 Subgingival curettage and root planning per full mouth treatment
9453 Occlusal adjustment (limited) per quadrant (minor spot grinding)
9472 Gingivectomy or gingivoplasty per quadrant
9473 Osseous and mucogingival surgery, per quadrant
9474 Gingivectomy or gingivoplasty treatment per tooth, (fewer than six teeth)

ENDODONTICS
(9500-9599)

9501 Therapeutic pulpotomy
9502 Vital pulpotomy
9503 Recalcification, includes temporary restoration, per tooth
9511 Anterior root canal therapy
9512 Bicuspid root canal therapy
9513 Molar root canal therapy
9530 Apicoectomy-surgical procedure in conjunction with root canal filling
9531 Apicoectomy (separate surgical procedure), per tooth
9534 Apexification/Apexogenesis (therapeutic apical closure), per treatment

RESTORATIVE DENTISTRY
(9600-9699)

Amalgam Restorations
9600 One surface, primary tooth
9601 Two surfaces, primary tooth
9602 Three surfaces, primary tooth
9603 Four or more surfaces, primary tooth (maximum)
9611 One surface, permanent tooth
9612 Two surfaces, permanent tooth
9613 Three surfaces, permanent tooth
9614 Four or more surfaces, permanent tooth (maximum)

Silicate, Composite, Plastic Restorations

9640 Silicate cement restoration
9641 Silicate restorations, two or more in a single tooth (maximum)
9645 Composite or plastic restoration
9646 Composite or plastic restorations, two or more in a single tooth (maximum)
9648 Pin retention, (per pin) maximum three per tooth

Crowns
9650 Crown, plastic (laboratory processed)
9651 Crown, plastic with metal
9652 Crown, porcelain
9653 Crown, porcelain fused to metal
9660 Crown, cast, full
9663 Crown, cast, three-quarters
9670 Crown, stainless steel, primary
9671 Crown, stainless steel, permanent
9672 Gold dowel post

PROSTHETICS
(9680-9799)

Pontics
9501 Therapeutic pulpotomy
9680 Fixed bridge pontic, cast metal
9681 Fixed bridge pontic, slotted facing
9682 Fixed bridge pontic, slotted pontic
9692 Fixed bridge pontic, porcelain fused to metal
9693 Fixed bridge pontic, plastic processed to metal

Recementing
9685 Recement inlay, facing, pontic
9686 Recement crown
9687 Recement bridge

Repairs, Crown and Bridge
9690 Repair fixed bridge
9694 Replace broken tru-pontic
9695 Replace broken facing, post intact
9696 Replace broken facing, post backing broken

Removable Prosthodontics
9700 Complete maxillary denture
9701 Complete mandibular denture

Procedure Number

9702 Partial upper or lower denture with two assembled wrought wire or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base
9703 Partial upper or lower denture with cast chrome skeleton, two cast clasps, and necessary teeth
9704 Clasp, third and each additional clasp for procedure 9703
9705 Stress breaker, extra
9706 Partial upper or lower stayplate, acrylic-base fee, teeth and clasps extra
9708 Partial upper or lower denture, all acrylic, with two assembled wrought wire clasps having two clasp arms, but no rests, and necessary teeth
9709 Clasp, third and each additional for Procedure 9708
9712 Clasp, third and each additional for Procedure 9702
9716 Clasp or teeth, each for Procedure 9706
9720 Denture adjustment, per visit
9721 Reline-office, cold cure
9722 Reline-laboratory processed
9723 Tissue conditioning, per denture
9724 Denture duplication ("jump," "reconstruction") denture base including necessary tooth replacement, per denture

Repairs, Dentures, Acrylic

9750 Repair broken denture base only (complete or partial)
9751 Repair broken denture base and replace one broken denture tooth (maximum two)
9752 Each additional denture tooth replaced on 9751 repair (maximum two)
9753 Replace one broken denture tooth only (complete or partial)
9754 Each additional denture tooth replaced on 9753 repair (maximum two)
9755 Adding first tooth to partial denture to replace newly extracted natural tooth
9756 Each additional natural tooth replaced on 9755 repair (maximum two)
9757 Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and rest to an existing 9702 partial denture
9758 Each additional new or replacement clasp for repair 9757 (maximum two)
9759 Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 9708 partial denture
9760 Each additional new or replacement clasp for repair 9759 (maximum two)
9761 Reattaching clasp on partial denture, clasp intact, each (maximum two)
9762 Add a new or replace a broken cast chrome cobalt clasp with two clasp arms and rest to an existing 9703 partial denture
9763 Each additional new or replacement clasp for repair 9762 (maximum two)

MALOCCLUSION CASES

9550 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films)
9551 Initial Orthodontic Examination/Handicapping Labial-Lingual Deviation Index
9552 Banding and materials
9554 Per treatment visit-24 visits maximum. One visit maximum per calendar month

CLEFT PALATE CASES

Primary Dentition

9560 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films, procedure code 9956 and 9957 including tracing are separately payable at stated fee schedule)
9562 Banding and materials
9564 Per treatment visit-10 visits maximum. One visit maximum per calendar month

Mixed Dentition

9570 Banding and materials
9572 Per treatment visit-14 visits maximum. One visit maximum per calendar month

Permanent Dentition

9580 Banding and materials
9582 Per treatment visit-30 visits maximum. One visit maximum per calendar month

FACIAL GROWTH MANAGEMENT

9590 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films, procedure code 9956 and 9957 including tracing, are separately payable at stated fee schedule)
9592 Quarterly-observation, maximum six quarters
9594 Progress records prior to treatment
9596 Banding and materials

Procedure Number

9598 Per Treatment visit-24 visits maximum. One visit maximum per calendar month

RETENTION (MALOCCLUSION, CLEFT PALATE, AND FACIAL GROWTH MANAGEMENT CASES)

9556 Quarterly-observation-six quarters maximum
9599 Retainer, removable, for each upper and lower

SPACE MAINTAINERS (9800-9899)

9800 Fixed, unilateral band type (including band)
9801 Removable plastic with two stainless steel round wire clasps or rests
9802 Each additional clasp or rest (for 9801 only)
9811 Fixed, unilateral stainless steel crown type (including crown, Procedure 9670 or 9671)
9812 Fixed, bilateral lingual or palatal bar type
9832 Fixed or removable appliance to control harmful habit

FRACTURES AND DISLOCATIONS (9900-9999)
(Includes Usual Follow-up Care)

9900 Maxilla, open reduction, simple
9901 Maxilla, closed reduction, simple
9902 Mandible, open reduction, simple
9903 Mandible, closed reduction, simple
9904 Maxilla, closed reduction, compound
9905 Maxilla, open reduction, compound
9906 Mandible, closed reduction, compound
9907 Mandible, open reduction, compound
9913 Reduction of dislocation of temporormandibular joint
9915 Treatment of malar fracture, simple, closed reduction
9916 Treatment of malar fracture, simple or compound depressed, open reduction

DIAGNOSTIC SERVICES

9950 Clinical Examination and Consultation, Including Study Models
9952 Prosthetic Evaluation and Treatment Plan, Including Study Models
9955 TMJ Series radiographs
9956 Cephalometric Head Film, single, first film, Including tracing
9957 Cephalometric Head Film, Each Additional Film, Including tracing

Procedure Number

MAXILLOFACIAL PROSTHETIC SERVICES

9960 Speech appliance transitional with or without pharyngeal extension
9962 Speech appliance, permanent, edentulous, with or without pharyngeal extension
9964 Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension
9966 Palatal lift, interim
9968 Palatal lift, permanent, cast framework
9970 Obturator immediate surgical, routine
9971 Obturator immediate surgical, complex
9972 Obturator permanent, complex
9973 Resection prosthesis, permanent edentulous, complex
9974 Resection prosthesis, permanent edentulous, routine
9975 Resection prosthesis, permanent, partially edentulous, complex
9976 Repositioner, mandibular, two piece
9977 Removal facial prosthesis
9978 Splints and stents
9979 Radiation therapy fluoride carrier
9980 Repairs, maxillofacial prosthesis
9981 Rebase, laboratory processed, maxillofacial prosthesis
9982 Balancing (opposing) maxillofacial appliance

MAXILLOFACIAL SURGICAL PROCEDURES

9985 Maxillofacial surgical procedures

TEMPOROMANDIBULAR JOINT DYSFUNCTION MANAGEMENT

9990 Occlusal analysis, including report and/or models
9992 Occlusal adjustments, limited centric and excursive adjustments including records and/or models
9994 Occlusal balancing, altering centric relations, including records and/or models
9995 Orthopedic stabilizing appliance, disocclusion splint
9996 Postoperative visits, symptomatic care and counseling
9998 Unlisted therapeutic services

ATTACHMENT B

ACCESS DENTAL

GRIEVANCE FORM

Access Dental Plan, Inc. ("the Plan") takes very seriously problems raised by its members and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Plan Member Services Representative at 916-646-2130 or any Plan provider representative.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: ( ) -

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: _____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: _____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-800-707-6453) and use your health plan' s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department' s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

PLEASE MAIL THIS FORM TO:

Grievance Department
Access Dental Plan
P.O. Box: 659005
Sacramento, CA 95865-9005

Please do not write below this line – for Plan use only.

Name of Person Taking Complaint:_____	Date Received:_____	Time Received:_____	Date/Time Logged:_____

ACCESS DENTAL

ATTACHMENT C

PUBLIC POLICY COMMITTEE APPLICATION

Thank you for your interest in the Public Policy Committee for Access Dental Plan. Please complete this form and return by mail. If you are asked to join the Public Policy Committee, you will receive a check for $100.00 for each meeting that you attend. **Please refer to the appropriate section of this booklet for a description of the Public Policy Committee.**

Name: _____ Date of Birth: ___/___/___

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip Code: _____ Telephone: (___) ___-_____

Work Experience: (List Most Recent Employer)

Employer: _____

Employment Dates: _____ to _____

Job Title: _____

Responsibilities: _____

_____

Educational Background: (Highest Level Completed)

- ☐ 8th Grade
- ☐ High School Graduate
- ☐ Associate of Arts
- ☐ College Graduate
- ☐ Graduate School

Provide a brief description as to why you would like to serve on Access Dental Plan's Public Policy Committee:

_____

_____

_____

_____

Signature: _____ **Date:** _____

FOLD HERE

Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826

Place stamp here

ACCESS DENTAL PLAN
8890 CAL CENTER DRIVE
SACRAMENTO, CA 95826

ATTACHMENT D

Federally Required Adult Dental Services (FRADS)

The following procedure codes will continue as reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older beginning July 1, 2009

***Please note**: The CDT-4 procedure codes marked with an asterisk (D0220, D0230, D0250, D0260, D0290, D0310 and D0330) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Table 1

CDT-4 Code	CDT-4 Code Description
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical each additional film
D0250*	Extraoral - first film
D0260*	Extraoral - each additional film
D0290*	Posterior - anterior or lateral skull and facial bone survey film
D0310*	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330*	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay
D2920	Recement crown
D2940	Sedative filling
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint

CDT-4 Code	CDT-4 Code Description
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greaterthan 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	D7465 Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7520	Incision and drainage of abscess - extraoral soft tissue
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body

CDT-4 Code	CDT-4 Code Description
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrostomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: discectomy
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical - per sextant or quadrant
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7955	Repair of maxillofacial soft and hard tissue defect
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/Extended care facility call
D9420	Hospital call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 2: Allowable Procedure Codes for Pregnant Women

CDT-4 Code	CDT-4 Code Description
D0120	Periodic oral evaluation
D0150	Comprehensive oral evaluation - new or established patient
D1110	Prophylaxis - adult
D1204	Topical application of fluoride (prophylaxis not included) – adult
D1205	Topical application of fluoride (including prophylaxis) - adult
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant
D4920	Unscheduled dressing change (by someone other than treating dentist)
D9951	Occlusal adjustment - limited