

Most Common Questions

WHAT IS A "MANAGED CARE" DENTAL PLAN?

A "Managed Care" dental plan contracts directly with licensed dental professionals to deliver quality dental care to its members.

HOW TO USE YOUR PLAN?

General Dental Services: Please select a dental office from the list of contracted Plan providers and indicate the dental office and ID# on the enrollment form. The Plan will assist you in selecting a dentist whenever you request such assistance. Thereafter, to obtain services, you need only contact the selected Plan provider and make an appointment. In the event you are dissatisfied with any Plan provider selected, for any reason, and desire to transfer to another, you may do so by contacting the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

Specialty Services: Should your treatment plan require the services of a specialist you will be referred by your Plan provider. All benefits and copayments apply to specialty services provided the referral has the prior approval of the Plan's Dental Director. If you need assistance with obtaining a specialty referral, please contact the Customer Care Department listed below.

Emergency Services or Urgent Care: Should you need urgent care, or are experiencing a dental emergency, please contact your Plan provider and indicate that you are in need of urgent or emergency care. If you need assistance with obtaining emergency or urgent care from your Plan provider, or are out of the area, you may contact the Customer Care Department at 1-800-999-3367 during normal business hours to arrange for out-of-area emergency care.

After Hours Care: If you need services after hours, first contact your assigned Plan provider. Plan providers are required to have 24-hour access to on-call care. If you are unable to contact your Plan provider, this plan provides for reimbursement for any emergency or after hours care out of the area up to \$100, less any usual copayments required for any procedures performed on a fee-for-service basis. If you need such care after hours, you must notify the Plan within 48 hours of receiving care from a non-participating provider.

Out-of-Area Care: To receive dental care out of your area, first contact the Customer Care Department at 1-800-999-3367 to determine if you can be served by another contracted Plan provider. If you are more than 50 miles from a contracted Plan provider, you may be directed to seek care from a non-Plan provider. If you need services after hours, please refer to the above After Hours Care section.

WHAT ARE THE BENEFITS?

PREVENTIVE	BASIC	MAJOR
Exams	Fillings	Crowns
Cleanings	Simple Extractions	Molar Root Canal
X-rays		Dentures
		Bridges
		Periodontal Surgery

HOW IS CARE RECEIVED?

The member may receive care by simply calling the selected dental location to schedule an appointment. There are no forms or cards required.

WHAT ABOUT MISSED APPOINTMENTS?

If a member fails to cancel an appointment at least 24 hours in advance, a "failed appointment fee" will be charged and no further appointments will be made until the cancellation fee is paid.



DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC.
800-999-3367 • 925-363-6000
PUD -7007 (10/08)

Additional information regarding your plan benefits may be obtained by calling the Plan office at 1-800-999-3367.

400-3724



FOR ACTIVE AND RETIREE EMPLOYEES OF THE CITY AND COUNTY OF SAN FRANCISCO

Benefit Schedule

HOW DOES YOUR DENTAL PLAN WORK?

DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC. ("DBP-CA") has created a plan that offers our members quality dental health services at a significant savings. We have contracted with quality, local dental professionals to provide services to you and your eligible dependents at no cost or for low fixed copayments. The following is an example of the potential savings on a typical case:

	PUD	Usual & Customary Fees
Office Exam & X-rays	No Charge	\$45
Cleanings (2) - one every 6 months	No Charge	\$90

TAKE ADVANTAGE OF THE BENEFITS

In addition to substantial savings, there are many other advantages as described in this brochure. Under this plan, there are **no claim forms** to complete, **no deductibles** to be met and **no yearly dollar maximum** of coverage.

MEMBERSHIP ELIGIBILITY

This plan is designed for the employee and, if eligible, his/her family. Unless stated otherwise by your group, coverage is extended to the spouse and/or unmarried dependent children. Dependent children include: 1. All natural, 2. Adopted, 3. Step-children and children of a domestic partner. An unmarried dependent child will be eligible to age 19, or age 25 if a full-time student. Automatic coverage is provided for mentally and/or physically challenged dependent children.

CHOOSE YOUR DENTIST AND OFFICE

You and your family choose your dentist from a wide network of private dental offices. A list of dental offices is provided to permit each member to choose the most convenient office. The member and dependents may select different dental offices. If so desired, you may transfer to a different Plan office. Simply notify the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

OTHER BENEFITS

- Maximum benefits allowed annually per person are unlimited • No deductibles • No claim forms required
- You know your exact "out-of-pocket" costs, if any • You may select the participating dentist of your choice.

ENROLLMENT PROCEDURE

Simply fill out and return the City and County of San Francisco enrollment form to Health Service Systems. For more information call 800-999-3367.

OTHER CHARGES

The member pays the copayments listed on the Benefit Copayment Schedule for each dental procedure completed by the dentist. These fees must be paid directly to the participating dental office where dental treatment is received. Payments are due on the day of service unless prior arrangements have been made with your dental provider.

TERMINATION OF BENEFITS

1. On expiration date of dental coverage.
2. When dependent member gets married, attains the age of 19 or ceases to be a full-time student prior to age 25.
3. Permitting or committing fraud. In the event of termination, the Plan provider shall complete any procedures listed on the Benefit Copayment Schedule commenced prior to the termination date, and the member is required to pay all copayments in accordance with the Benefit Copayment Schedule.
4. Members who violate the Plan's rules may have their benefits suspended or be transferred to an indemnity plan.

GOLD MATERIALS

If gold materials, not normally prescribed, are requested for fillings, crowns, bridges, or prosthetic devices, there will be an additional charge based on the amount of gold used.

BASIC METHOD OF REIMBURSEMENT

The Plan contracts with general and specialized dentists to provide quality dental services for eligible group members. The Plan compensates its providers using direct reimbursement, discounted fee for service, fee for service and capitation. The Plan does not use provider incentives or bonus plans to influence specific dental care decisions.

SECOND OPINION

If the member has a treatment question or concern that cannot be addressed by the member's current Plan provider and/or Dental Director the member may request a second opinion from another Plan dentist. There is no cost for this second opinion except for applicable copayments, if any. The second opinion will be performed by a contracted Plan general dentist or specialist. A second opinion must be arranged through the Customer Care Department by calling 800-999-3367..

ACUTE CARE

The Plan is responsible for providing emergency dental services to our members immediately upon member enrollment in our dental plan. Emergency services are subject to the limitations and exclusions found in your evidence of coverage.

BINDING ARBITRATION

In the event you are unable to utilize the "binding arbitration" provision contained in the contract because you believe it will cause you "extreme financial hardship," you may request financial assistance from the Plan. Eligible enrollees may request a copy of the Plan's written policy which includes information on how enrollees may request financial assistance in order to exercise all of their rights under this policy.

GRIEVANCE PROCEDURE

Any complaints may be referred to the Plan's Customer Care Department by calling 1-800-999-3367. Complaint forms and a copy of the grievance procedure are available from the Plan.

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 1-800-999-3367 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.

DBP-CA does not discriminate or tolerate discrimination of any kind against an enrollee who has filed a complaint with the Plan of any kind (i.e. against a provider or the Plan itself, or any other complaint). No Plan contract shall be cancelled because an enrollee filed a complaint with the Plan.

PRINCIPAL LIMITATIONS FOR ACTIVES

Set forth below are the limitations that are applicable to this Plan:

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy);
2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Denture relines are limited to one per denture during any 12 consecutive months;
5. Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair;
6. Treatment for conditions is generally limited to conventional techniques and does not include splinting, hemisection, implants, overdentures, grafting, precision attachments, duplicate dentures and appliances for the treatment of bruxism other than occlusal guards;
7. The plan allows up to five units of crown or bridge work per arch. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit;
8. Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months;
9. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period;
10. Bitewing x-rays are limited to not more than one series of four films in any six month period;
11. Full mouth x-rays and/or panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bite wing x-rays;
12. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars and bicuspids up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application;
13. Single unit cast metal and/or ceramic restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials. Crown build ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays;
14. Cosmetic dental care is limited to composite restorations on posterior teeth when a Plan Dentist determines treatment to be appropriate dental care;

CITY AND COUNTY OF SAN FRANCISCO RETIREES COPAYMENT SCHEDULE

ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES		
0120	Periodic Oral Exam-Established Patient	0
0140	Limited Oral Evaluation-Focused	0
0145	Oral Eval-Pt Under 3 Years/Counseling	0
0150	Comprehensive Oral Evaluation	0
0160	Detailed & Extensive Oral Exam	0
0170	Re-evaluation - Limited	0
0180	Comprehensive Periodontal Eval	0
0210	Intraoral-Complete (Inc. Bitewings)	0
0220	Intraoral-Periapical First Film	0
0230	Intraoral-Periapical Each Additional	0
0240	Intraoral-Occlusal Film	0
0250	Extraoral-First Film	0
0260	Extraoral-Each Additional Film	0
0270	Bitewings-Single Film	0
0272	Bitewings-Two Films	0
0273	Bitewings-Three Films	0
0274	Bitewings-Four Films	0
0277	Vertical Bitewings - 7 to 8 Films	0
0330	Panorex Film	0
0460	Pulp Vitality Tests	0
PREVENTIVE SERVICES		
1110	Prophylaxis, Adult	0
1120	Prophylaxis, Child	0
1203	Topical Fluoride w/o Prophy - Child	0
1204	Topical Fluoride w/o Prophy - Adult	0
1206	Topical Flouride Varnish	0
1330	Oral Hygiene Instruction	0
1351	Sealant, Per Tooth	5
1510	Space Maintainer-Fixed-Unilateral	30
1515	Space Maintainer-Fixed - Bilateral	30
1520	Space Maintainer-Rem.-Unilateral	30
1525	Space Maintainer-Remov.-Bilateral	30
BASIC RESTORATIVE SERVICES		
2140	Amalgam 1 Surface	5
2150	Amalgam 2 Surfaces	5
2160	Amalgam 3 Surfaces	5
2161	Amalgam 4 or More Surfaces	5
2330	Resin Composite - 1 Surf., Ant.	5
2331	Resin Composite -- 2 Surf., Ant.	5
2332	Resin Composite-3 Surf., Ant.	5
2335	Resin Comp 4+ Surf or Incisal Edge, Ant	5
2390	Composite Crown -- Anterior	5
ADVANCED RESTORATIVE SERVICES		
2740	Crown - porc/ceramic substrate*	85
2750	Crown-Porc Fused/Hi Noble Metal*	85
2751	Crown-Porc Fused/Pred Base Metal*	85
2752	Crown-Porc Fused To Noble Metal*	85
2780	Crown-3/4 Cast High Noble Metal*	85
2781	Crown-3/4 Cast/Predom Base Metal	85
2782	Crown-3/4 Cast Noble Metal*	85
2783	Crown - 3/4 porcelain/ceramic*	85
2790	Crown-Full Cast High Noble Metal*	85
2791	Crown-Full Cast/Predom Base Metal	85
2792	Crown-Full Cast Noble Metal*	85
2794	Crown-Titanium*	85
2910	Recem. Inlay/Onlay/Partial Coverage Rest	0
2915	Recement Cast/Prefab Post & Core	0
2920	Recement Crown	0
2930	Prefab. Stain. St. Crown Prim	25
2931	Prefab. Stain. St. Crown Perm	25
2934	Prefab Esthetic Coated Stain St Crn Prim*	25
2940	Sedative Fillings	0
2950	Core Build-up, including pins	0
2951	Pin Retention-Per Tooth, w/Rest	0
2952	Cast Post/Core In Add. To Crown, Ind. Fab*	25
2953	Ea Add Indirect Fab Post-Same Tooth*	6
2954	Prefab/Post & Core In Add. To Crown	25
2957	Ea add.gb prefab. Post - same tooth	6
2970	Temporary Crown (Fractured Tooth)	25
ENDODONTIC SERVICES		
3110	Pulp Cap-Direct (w/o Final Rest.)	0
3120	Pulp Cap-Indirect (w/o Final Rest.)	0
3220	Therapeutic Pulp. (w/o Final Rest)	0
3221	Gross Pulpal debridement	10
3230	Pulpal Therapy - Ant. Primary Tooth	0
3240	Pulpal Therapy - Posterior Primary Tooth	0
3310	Root Canal, Anterior (w/o Final Rest)	50
3320	Root Canal, Bicuspid (w/o Final Rest)	50

3330	Root Canal, Molar (w/o Final Rest)	50
3332	Incomp. Endo Ther., Inoper/Unrest/Fx Tooth	0
3346	Retreatment Previous RCT - Anterior	50
3347	Retreatment Previous RCT - Bicuspid	50
3348	Retreatment Previous RCT - Molar	50
3410	Apicoectomy, Anterior	180
3421	Apicoectomy, Bicuspid (First Root)	180
3425	Apicoectomy, Molar (First Root)	180
3426	Apicoectomy, Each Additional Root	180
3430	Retrograde Filling (Per Root)	180
PERIODONTAL SERVICES		
4210	Gingivectomy/oplasty (4+ Teeth)	75
4211	Gingivectomy/oplasty (1-3 Teeth)	45
4240	Ging. Flap w/Root Planing (4+ Teeth)	325
4241	Gingival Flap With Rp (1 to 3 Teeth)	216
4260	Osseous Surgery (4+ Teeth)	325
4261	Osseous Surgery (1 to 3 Teeth)	216
4274	Distal/Proximal Wedge Procedure	325
4341	Perio Scaling/Root Planing, (4+ Teeth)	20
4342	Perio Scale & Rp, 1 To 3 Teeth	20
4355	Full Mouth Debridement	20
REMOVABLE PROSTHODONTICS		
5110	Complete Denture - Maxillary	125
5120	Complete Denture - Mandibular	125
5130	Immediate Denture - Maxillary	125
5140	Immediate Denture - Mandibular	125
5211	Maxillary Partial Denture - Resin Base	150
5212	Mandibular Partial Dent - Resin Base	150
5213	Max Partial Denture - Cast Mtl Frame*	150
5214	Mand Partial Denture-Cast Mtl Frame*	150
5225	Max Partial Denture-Flexible Base*	150
5226	Mand Partial Denture-Flexible Base*	150
5410	Adjust Complete Denture - Maxillary	0
5411	Adjust Complete Denture - Mandibular	0
5421	Adjust Partial Denture - Maxillary	0
5422	Adjust Partial Denture - Mandibular	0
5510	Repair Broken Complete Dent. Base	15
5520	Replace Missing/Broken Teeth/Tooth	15
5610	Repair Resin Denture Base	15
5620	Repair Cast Framework	15
5630	Repair Or Replace Broken Clasp	15
5640	Replace Broken Teeth-Per Tooth	15
5650	Add Tooth to Existing Partial Denture	25
5660	Add Clasp to Existing Partial Denture	25
5670	Replace All Teeth - Maxillary	135
5671	Replace All Teeth - Mandibular	135
5710	Rebase Comp. Maxillary Denture	75
5711	Rebase Comp. Mandibular Denture	75
5720	Rebase Maxillary Partial Denture	75
5721	Rebase Mandibular Partial Denture	75
5730	Reline Comp. Maxillary Denture-Chair	50
5731	Reline Comp. Mandibular Denture-Chair	50
5740	Reline Maxillary Partial Denture-Chair	50
5741	Reline Mandibular Partial Denture-Chair	50
5750	Reline Complete Maxillary Denture-Lab	50
5751	Reline Complete Mandibular Dent.-Lab	50
5760	Reline Maxillary Partial Denture-Lab	50
5761	Reline Mandibular Partial Denture-Lab	50
5820	Interim Partial Denture, Maxillary	75
5821	Interim Partial Denture, Mandibular	75
FIXED PROSTHODONTICS		
6210	Pontic-Cast High Noble Metal*	85
6211	Pontic-Cast Predom Base Metal	85
6212	Pontic-Cast Noble Metal*	85
6214	Pontic-Titanium*	85
6240	Pontic-Porcelain/High Noble Metal*	85
6241	Pontic-Porcelain/Predom Base Metal*	85
6242	Pontic - Porcelain/Noble Metal*	85
6245	Pontic-Porcelain/Ceramic*	85
6250	Pontic Resin with Hi Noble Metal*	85
6251	Pontic Resin with Predom. Base Metal*	85
6252	Pontic Resin with Noble Metal*	85
6720	Crown Resin Hi Noble Metal*	85
6721	Crown Res. with Predom. Base Mtl*	85
6722	Crown Res. with Noble Metal*	85
6740	Crown-Porcelain/Ceramic*	85
6750	Crown-Porc/High Noble Metal*	85
6751	Crown-Porc/Predom Base Metal*	85
6752	Crown-Porc/Noble Metal*	85
6780	Crown-3/4 Cast High Noble Metal*	85
6781	Crown-3/4 Cast Predom Based Metal	85
6782	Crown-3/4 Cast Noble Metal*	85
6783	Crown-3/4 Porcelain/Ceramic*	85

6790	Crown-Full Cast High Noble Metal*	85
6791	Crown-Full Cast Predom Base Metal	85
6792	Crown-Full Cast Noble Metal*	85
6794	Crown-Titanium*	85
6930	Recement Fixed Partial Denture	0
6970	Post/Core-Add to Bridge Retainer, Ind. Fab*	25
6972	Prefab. Post/Core-Add to Fixed Part Ret	25
6973	Core build up for retainer, including pins	0
6976	Each Add'l Indirectly Fab Post-Same Tooth*	6
6977	Each Additional Prefab Post-Same Tooth*	6
ORAL SURGERY		
7111	Extraction Coronal Remnants-Primary Tooth	3
7140	Extraction-Erupted Tooth/Exposed Root	5
7210	Surg Rem/Erupted Tooth-Req Elevation	30
7220	Removal Impacted Tooth - Soft Tissue	50
7230	Removal Impacted Tooth - Part Bony	70
7240	Rem. Impacted Tooth-Comp Bony	90
7250	Surgical Removal Residual Tooth Roots	30
7285	Biopsy of Oral Tissue-Hard	0
7286	Biopsy of Oral Tissue-Soft	0
7287	Exfoliative Cytological Sample Collection	0
7288	Brush Biopsy-Trans Sample Collection	0
7310	Alveoplasty w/Ext. 4+Teeth, Per Quad	0
7311	Alveoloplasty w/Ext (1 to 3 Teeth/Sp)	0
7320	Alveoloplasty w/o Ext. 4+Teeth, Per Quad	0
7321	Alveoloplasty w/o Ext (1 to 3 Teeth/Sp)	0
7960	Frenectomy-Separate Procedure	0
7963	Frenuloplasty	0
ADJUNCTIVE SERVICES		
9110	Palliative (Emergency) Treatment	10
9120	Fixed Partial Denture Sectioning	0
9215	Local Anesthesia	0
9215	Intravenous Sed/Analgesia-1st 30 Min	0
9310	Consultation-Provided by Another DDS	0
9430	Office Visit for Observation	0
9440	Office Visit After Regular Sched Hours	20
9450	Case Presentation	0
9940	Occlusal Guard, By Report	25
9942	Repair/Reline of Occlusal Guard	15
9952	Occlusal Adjustment Complete	0
9971	Odontoplasty	10
10001	FAILED APPOINTMENT	10

*Resin, porcelain, and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for fillings, crowns, pontics, bridges, or prosthetic devices, there will be an additional charge, based on the amount of metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

**CITY AND COUNTY OF SAN FRANCISCO
ACTIVES COPAYMENT SCHEDULE**

ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES		
0120	Periodic Oral Exam-Established Patient	0
0140	Limited Oral Evaluation-Focused	0
0145	Oral Eval-Pt Under 3 Years/Counseling	0
0150	Comprehensive Oral Evaluation	0
0160	Detailed & Extensive Oral Exam	0
0170	Re-evaluation - Limited	0
0180	Comprehensive Periodontal Eval	0
0210	Intraoral-Complete (Inc. Bitewings)	0
0220	Intraoral-Periapical First Film	0
0230	Intraoral-Periapical Each Additional	0
0240	Intraoral-Occlusal Film	0
0250	Extraoral-First Film	0
0260	Extraoral-Each Additional Film	0
0270	Bitewings-Single Film	0
0272	Bitewings-Two Films	0
0273	Bitewings-Three Films	0
0274	Bitewings-Four Films	0
0277	Vertical Bitewings - 7 to 8 Films	0
0330	Panorex Film	0
0340	Cephalometric Film	0
0421	Genetic Test for Subscap to Oral Dis	0
0425	Caries Susceptibility Tests	0
0460	Pulp Vitality Tests	0
0470	Diagnostic Casts	0
PREVENTIVE SERVICES		
1110	Prophylaxis, Adult	0
1120	Prophylaxis, Child	0
1203	Topical Fluoride w/o Proply - Child	0
1204	Topical Fluoride w/o Proply - Adult	0
1206	Topical Fluoride Varnish	0
1310	Nutritional Counseling	0
1320	Tobacco Counseling	0
1330	Oral Hygiene Instruction	0
1351	Sealant, Per Tooth	5
1510	Space Maintainer-Fixed - Unilateral	0
1515	Space Maintainer-Fixed - Bilateral	0
1520	Space Maintainer-Rem. - Unilateral	0
1525	Space Maintainer-Remov. - Bilateral	0
1550	Recementation of Space Maintainer	0
1555	Removal of Fixed Space Maintainer	0
BASIC RESTORATIVE SERVICES		
2140	Amalgam 1 Surface	0
2150	Amalgam 2 Surfaces	0
2160	Amalgam 3 Surfaces	0
2161	Amalgam 4 or More Surfaces	0
2330	Resin Composite - 1 Surf., Ant.	0
2331	Resin Composite - 2 Surf., Ant.	0
2332	Resin Composite - 3 Surf., Ant.	0
2335	Resin Comp 4+ Surf or Incisal Edge, Ant	0
ADVANCED RESTORATIVE SERVICES		
2710	Crown - Resin Based Composite Indirect*	0
2712	Crown - 3/4 Resin Based Composite Indirect*	0
2720	Crown - Resin with Hi Noble Metal*	0
2721	Crown - Resin with Predom. Base Metal*	0
2722	Crown - Resin with Noble Metal*	0
2740	Crown - Porc/Ceramic Substrate	0
2750	Crown - Porc Fused/Hi Noble Metal*	0
2751	Crown - Porc Fused/Pred Base Metal*	0
2752	Crown - Porc Fused To Noble Metal*	0
2780	Crown - 3/4 Cast High Noble Metal*	0
2781	Crown - 3/4 Cast/Predom Base Metal	0
2782	Crown - 3/4 Cast Noble Metal*	0
2783	Crown - 3/4 Porcelain/Ceramic*	0
2790	Crown - Full Cast High Noble Metal*	0
2791	Crown - Full Cast/Predom Base Metal	0
2792	Crown - Full Cast Noble Metal*	0
2794	Crown - Titanium*	0
2910	Recem. Inlay/Onlay/Partial Coverage Rest	0
2915	Recement Cast/Prefab Post & Core	0
2920	Recement Crown	0
2930	Prefab. Stain. St. Crown Prim	0
2931	Prefab. Stain. St. Crown Perm	0
2932	Prefab. Resin Crown*	0
2934	Prefab Esthetic Coated Stain St Crn Prim*	0
2940	Sedative Fillings	0
2950	Core Build-up, including pins	0
2951	Pin Retention - Per Tooth, w/Rest	0
2952	Cast Post/Core In Add. To Crown, Ind. Fab	0

2953	Ea Add Indirect Fab Post - Same Tooth	0
2954	Prefab/Post & Core In Add. To Crown	0
2957	Ea add. Prefab. Post - Same Tooth	0
2970	Temporary Crown (Fractured Tooth)	0
ENDODONTIC SERVICES		
3110	Pulp Cap-Direct (w/o Final Rest.)	0
3120	Pulp Cap-Indirect (w/o Final Rest.)	0
3220	Therapeutic Pulp. (w/o Final Rest)	0
3221	Gross Pulpal Debridement	0
3230	Pulpal Therapy - Ant. Primary Tooth	0
3240	Pulpal Therapy - Posterior Primary Tooth	0
3310	Root Canal, Anterior (w/o Final Rest)	0
3320	Root Canal, Bicuspid (w/o Final Rest)	0
3330	Root Canal, Molar (w/o Final Rest)	0
3332	Incomp. Endo Ther., Inoper/Unrest/Fx Tooth	0
3346	Retreatment Previous RCT - Anterior	0
3347	Retreatment Previous RCT - Bicuspid	0
3348	Retreatment Previous RCT - Molar	0
3351	Apexification, 1st visit	0
3410	Apicoectomy, Anterior	0
3421	Apicoectomy, Bicuspid (First Root)	0
3425	Apicoectomy, Molar (First Root)	0
3426	Apicoectomy, Each Additional Root	0
3430	Retrograde Filling (Per Root)	0
3450	Root Amputation (Per Root)	0
3920	Hemisection (Inc. Root Rem.) w/o RCT	0
PERIODONTAL SERVICES		
4210	Gingivectomy/oplasty (4+ Teeth)	0
4211	Gingivectomy/oplasty (1-3 Teeth)	0
4240	Ging. Flap w/Root Planing (4+ Teeth)	0
4241	Gingival Flap With Rp (1 to 3 Teeth)	0
4260	Osseous Surgery (4+ Teeth)	0
4261	Osseous Surgery (1 to 3 Teeth)	0
4263	Bone Replacement Graft-1st Site/Quad	0
4264	Bone Rep Graft-Ea Add Site in Quad	0
4270	Pedicle Soft Tissue Graft Procedure	0
4271	Free Soft Tissue Graft (donor site surg)	0
4274	Distal/Proximal Wedge Procedure	0
4341	Perio Scaling/Root Planing, (4+ Teeth)	0
4342	Perio Scale & Rp, 1 To 3 Teeth	0
4910	Perio. Maint. Procedure	0
REMOVABLE PROSTHODONTICS		
5110	Complete Denture - Maxillary	0
5120	Complete Denture - Mandibular	0
5130	Immediate Denture - Maxillary	0
5140	Immediate Denture - Mandibular	0
5211	Maxillary Partial Denture - Resin Base	0
5212	Mandibular Partial Dent - Resin Base	0
5213	Max Partial Denture - Cast Mtl Frame*	0
5214	Mand Partial Denture - Cast Mtl Frame*	0
5225	Max Partial Denture - Flexible Base*	0
5226	Mand Partial Denture - Flexible Base*	0
5410	Adjust Complete Denture - Maxillary	0
5411	Adjust Complete Denture - Mandibular	0
5421	Adjust Partial Denture - Maxillary	0
5422	Adjust Partial Denture - Mandibular	0
5510	Repair Broken Complete Dent. Base	0
5520	Replace Missing/Broken Teeth/Tooth	0
5610	Repair Resin Denture Base	0
5620	Repair Cast Framework	0
5630	Repair Or Replace Broken Clasp	0
5640	Replace Broken Teeth - Per Tooth	0
5650	Add Tooth to Existing Partial Denture	0
5660	Add Clasp to Existing Partial Denture	0
5670	Replace All Teeth - Maxillary	0
5671	Replace All Teeth - Mandibular	0
5710	Rebase Comp. Maxillary Denture	0
5711	Rebase Comp. Mandibular Denture	0
5720	Rebase Maxillary Partial Denture	0
5721	Rebase Mandibular Partial Denture	0
5730	Reline Comp. Maxillary Denture - Chair	0
5731	Reline Comp. Mandibular Denture - Chair	0
5740	Reline Maxillary Partial Denture - Chair	0
5741	Reline Mandibular Partial Denture - Chair	0
5750	Reline Complete Maxillary Denture - Lab	0
5751	Reline Complete Mandibular Dent. - Lab	0
5760	Reline Maxillary Partial Denture - Lab	0
5761	Reline Mandibular Partial Denture - Lab	0
5820	Interim Partial Denture, Maxillary	0
5821	Interim Partial Denture, Mandibular	0
5850	Tissue Conditioning, Maxillary	0
5851	Tissue Conditioning, Mandibular	0

FIXED PROSTHODONTICS		
6205	Pontic - Indirect Resin Based Composite*	0
6210	Pontic - Cast High Noble Metal*	0
6211	Pontic - Cast Predom Base Metal	0
6212	Pontic - Cast Noble Metal*	0
6214	Pontic - Titanium*	0
6240	Pontic - Porcelain/High Noble Metal*	0
6241	Pontic - Porcelain/Predom Base Metal*	0
6242	Pontic - Porcelain/Noble Metal*	0
6245	Pontic - Porcelain/Ceramic*	0
6250	Pontic - Resin with Hi Noble Metal*	0
6251	Pontic - Resin with Predom. Base Metal*	0
6252	Pontic - Resin with Noble Metal*	0
6545	Retainer - Cast Mtl for Resin Fixed Pros	0
6548	Ret-Porc/Cer for Resin Bonded Fixed Pros*	0
6710	Crown - Indirect Resin Based Composite*	0
6720	Crown - Resin with Hi Noble Metal*	0
6721	Crown - Res. with Predom. Base Mtl*	0
6722	Crown - Res. with Noble Metal*	0
6740	Crown - Porcelain/Ceramic*	0
6750	Crown - Porc/High Noble Metal*	0
6751	Crown - Porc/Predom Base Metal*	0
6752	Crown - Porc/Noble Metal*	0
6780	Crown - 3/4 Cast High Noble Metal*	0
6781	Crown - 3/4 Cast Predom Based Metal	0
6782	Crown - 3/4 Cast Noble Metal*	0
6783	Crown - 3/4 Porcelain/Ceramic*	0
6790	Crown - Full Cast High Noble Metal*	0
6791	Crown - Full Cast Predom Base Metal	0
6792	Crown - Full Cast Noble Metal*	0
6794	Crown - Titanium*	0
6930	Recement Fixed Partial Denture	0
6970	Post/Core - Add to Bridge Retainer, Ind. Fab	0
6972	Prefab. Post/Core-Add to Fixed Part Ret	0
6973	Core build up for retainer, including pins	0
6976	Each Add'l Indirectly Fab Post - Same Tooth	0
6977	Each Additional Prefab Post - Same Tooth	0
ORAL SURGERY		
7111	Extraction Coronal Remnants - Primary Tooth	0
7140	Extraction - Erupted Tooth/Exposed Root	0
7210	Surg Rem/Erupted Tooth - Req Elevation	0
7220	Removal Impacted Tooth - Soft Tissue	0
7230	Removal Impacted Tooth - Part Bony	0
7240	Rem. Impacted Tooth-Comp Bony	0
7241	Rem. Impacted Tooth-Comp Bony w/Comp	0
7250	Surgical Removal Residual Tooth Roots	0
7285	Biopsy of Oral Tissue - Hard	0
7286	Biopsy of Oral Tissue - Soft	0
7287	Exfoliative Cytological Sample Collection	0
7288	Brush Biopsy-Trans Sample Collection	0
7310	Alveoloplasty w/Ext. 4+Teeth, Per Quad	0
7311	Alveoloplasty w/Ext (1 to 3 Teeth/Sp)	0
7320	Alveoloplasty w/o Ext. 4+Teeth, Per Quad	0
7321	Alveoloplasty w/o Ext (1 to 3 Teeth/Sp)	0
7340	Vestibuloplasty - Ridge Extension	0
7350	Vestibuloplasty - Ridge Ext w/Comp	0
7510	I & D of Abscess, Intraoral Soft Tissue	0
7511	I & D of Abscess, Intraoral Complicated	0
7520	I & D of Abscess, Extraoral Soft Tissue	0
7521	I & D of Abscess, Extraoral Complicated	0
7530	Removal of Foreign Body	0
7960	Frenectomy - Separate Procedure	0
7963	Frenuloplasty	0
ADJUNCTIVE SERVICES		
9110	Palliative (Emergency) Treatment	0
9120	Fixed Partial Denture Sectioning	0
9310	Consultation - Provided by Another DDS	0
9430	Office Visit for Observation	0
9440	Office Visit After Regular Sched Hours	25
9450	Case Presentation	0
9930	Treatment of Complications by Report	0
9940	Occlusal Guard, By Report	25
9942	Repair/Reline of Occlusal Guard	0
9951	Occlusal Adjustment Limited	0
9952	Occlusal Adjustment Complete	0
9971	Odontoplasty	0
10001	FAILED APPOINTMENT	25

*Resin, porcelain, and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for fillings, crowns, pontics, bridges, or prosthetic devices, there will be an additional charge, based on the amount of metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

PRINCIPAL EXCLUSIONS FOR ACTIVES

The following procedures and services are not included in the Plan:

- General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs;
- Dental conditions arising out of and due to member's employment or for which Worker's Compensation is payable. Services that are provided to the member by state government or agency thereof, or are provided without cost to the member by any municipality, county and/or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code;
- Treatment required by reason of war;
- Dental services performed in a hospital and related hospital fees;
- Treatment of fractures and dislocations;
- Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
- Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to members' eligibility with Company (e.g.: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics);
- Any service that is not specifically listed as a covered expense;
- Procedures, appliances or restorations to correct congenitally, and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, andodontia) and supernumerary teeth;
- Treatment/removal of malignancies, cysts over 1.25 centimeters, tumors and neoplasms;
- Dispensing of drugs not normally supplied in a dental office;
- Treatment as a result of accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth;
- Cases which in the professional opinion of the Company's attending dentist determines that a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
- Dental services received from any dental office other than a Plan Dentist's dental office, unless expressly authorized in writing by Company or as cited under "Out of Area Emergency Treatment."
- Prophylactic removal of asymptomatic, nonpathological impacted teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with ligation;
- Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
- Crown lengthening procedures;
- Replacement of long standing missing tooth/teeth in an otherwise stable dentition;
- Dental services and treatments for restoring tooth structure loss from wear, bruxism (other than occlusal guards, which are included in this plan), attrition and/or erosion; changing or restoring vertical dimension; and full mouth reconstruction to enhance occlusion; diagnosis and/or treatment of the temporomandibular joint (TMJ);
- Dental services that cannot be performed in the Plan Dentist's general dental office because of physical, medical or behavioral limitations of eligible members over the age of six years.

PRINCIPAL LIMITATIONS FOR RETIREES

Set forth below are the limitations that are applicable to this Plan:

- Dentures (full or partial): Dentures or appliances will be replaced only after 3 years have elapsed following any prior provision of such dentures or appliances under any Pacific Union Dental program. Replacements will be made only if the existing denture or appliance is unsatisfactory and cannot be made satisfactory.
 - Denture Relines: Twice a year.
 - Prophylaxis: Once every 6 months.
 - Full Mouth X-rays: Once initially and thereafter when diagnostically necessary.
 - Fluoride Treatment: Once every 6 months to age 18.
 - Reimbursement shall not be made for the cost of services secured from any other health care provider other than the member's Provider, unless authorized in writing by Pacific Union Dental.
 - Crowns or replacement of missing teeth with complete or partial dentures or fixed bridges are provided using standard procedures.
- PRINCIPAL EXCLUSIONS FOR RETIREES**
- The following procedures and services are not included in the Plan:
- Any treatment requested or appliances made which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
 - Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges.
 - General anesthesia.
 - Replacement of lost or stolen dentures, appliances or bridgework.
 - Treatment of malignancies, cysts and neoplasms.
 - Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorders, including, but not limited to, treatment of myofunctional, myo-skeletal, or temporomandibular joint dysfunctions (except occlusal guards for the treatment of bruxism) unless otherwise covered as an orthodontic benefit.
 - Implants.
 - Dental treatment started prior to the member's eligibility under this Plan or after a member's termination.
 - Any dental procedure unable to be performed in the dental office because of the general health and physical limits of the member, including but not limited to physical or emotional resistance or allergy to all commonly utilized local anesthetics; extremely contagious diseases which might endanger the staff and patients of a typical general dentistry office and severe medical problems which would make dental therapy at a typical general dentistry office unwise.
 - Those procedures requiring fixed prosthodontic restorations which are necessary for complete oral rehabilitation or reconstruction.
 - Any procedure not specifically listed as a covered benefit is available on a fee-for-service basis.

**CITY AND COUNTY OF SAN FRANCISCO
ORTHODONTIC BENEFITS
(Adult Coverage)**

I. ORTHODONTIC BENEFITS

Orthodontic services are provided as part of dental benefits provided by PACIFIC UNION DENTAL, subject to the following provisions:

- a) There shall be a one-time surcharge of \$1880.00 for a full-banded/2 year case, (Phase II treatment only). This fee includes retainers (with retention limited to 12 consecutive months, if necessary), plus an additional charge of no more than:

\$350.00 for start-up fees

Member's payment schedule as follows unless otherwise agreed upon between the member and the orthodontist:

\$500.00 at the inception of care (the placement of bands).

\$115.00 per month for 12 months.

- b) Orthodontic treatment must be provided by a member of the orthodontic panel who is providing said treatment under a contract with PACIFIC UNION DENTAL
- c) Plan benefits cover 24 months of usual and customary Phase II orthodontic treatment.

II. LOSS OF BENEFIT/RESIDUAL OBLIGATIONS

Should a member be terminated or become ineligible for benefits, the member is subject to the following provisions:

- a) Availability of the orthodontic benefits described herein will cease upon loss of members eligibility and/or termination of the Group Subscriber Agreement for any reason. In the event benefits terminated while members and/or dependents have treatment in progress, the member may complete treatment by payment of the lesser of the following:
 - 1) The number of months remaining in treatment times \$125 per month.
 - 2) \$3000 less any copayments (including start-up fees) paid prior to termination of this benefit.
- b) If a termination of benefits occurs due to a termination of the Group Subscriber Agreement, the group shall reserve the right to assign members residual obligation as described in (a) above to a successor organization.
- c) If member loses eligibility for 3 or more consecutive months they will be considered no longer eligible for orthodontic benefits, and (1) above would apply.

III. ADDITIONAL CHARGES

- a) Treatment that extends beyond 24 months will be subject to an office visit charge, which will be the members responsibility.
- b) The charge for each additional month will not exceed \$125.00 per month.

IV. SERVICES NOT PROVIDED

The following are not benefits included as part of orthodontic services provided by DBP-CA.

- a) Start-up including:
 - 1. Cephalometric x-rays*
 - 2. Tracings*
 - 3. Study models*
 - 4. Photos*
- b) Lost or broken appliances.
- c) Retreatment of orthodontic cases.
- d) Treatment in progress at inception of eligibility.
- e) Changes in treatment necessitated by accident of any kind.
- f) Extraction of teeth or surgical procedures performed for orthodontic purposes.
- g) Replacement (including bridgework) or restoration (including crowns) of teeth caused solely by the orthodontic treatment.
- h) Orthodontics for TMJ problems including assessment beyond that customarily provided in general practice.
- i) Cases involving:
 - 1. Surgical orthodontics.
 - 2. Myofunctional therapy.
 - 3. Cleft palate.
 - 4. Micrognathia.
 - 5. Macroglossia.
 - 6. Hormonal imbalances.
 - 7. Phase I orthodontic care.
 - 8. Orthodontic care prior to age ten or after the age of nineteen.
- j) Transfer of Orthodontic provider for any reason in the middle of treatment.
- k) Orthodontic cases extending beyond the 19th birthday are subject to loss of benefit residual obligation provision (refer to SECTION II LOSS OF BENEFIT/RESIDUAL OBLIGATIONS).
- l) Any treatment rendered by any noncontracted Orthodontic provider.

* Start up fees subject to additional combined charge not to exceed \$350.00.

**CITY AND COUNTY OF SAN FRANCISCO
ORTHODONTIC BENEFITS
(Child Coverage)**

I. ORTHODONTIC BENEFITS

Orthodontic services are provided as part of dental benefits provided by DBP-CA, subject to the following provisions:

- a) There shall be a one-time surcharge of \$1660.00 for a full-banded/2 year case, (Phase II treatment only). This fee includes retainers (with retention limited to 12 consecutive months, if necessary), plus an additional charge of no more than:

\$350.00 for start-up fees

Member's payment schedule as follows unless otherwise agreed upon between the member and the orthodontist:

\$400.00 at the inception of care (the placement of bands).

\$105.00 per month for 12 months.

- b) Orthodontic treatment is available for each eligible dependent between ages 10 and 19. Orthodontic care for dependent children over the ages of 19 is not a covered benefit.
- c) Orthodontic treatment must be provided by a member of the orthodontic panel who is providing said treatment under a contract with PACIFIC UNION DENTAL.
- d) Plan benefits cover 24 months of usual and customary Phase II orthodontic treatment.

II. LOSS OF BENEFIT/RESIDUAL OBLIGATIONS

Should a member be terminated or become ineligible for benefits, the member is subject to the following provisions:

- a) Availability of the orthodontic benefits described herein will cease upon loss of members eligibility and/or termination of the Group Subscriber Agreement for any reason. In the event benefits terminated while members and/or dependents have treatment in progress, the member may complete treatment by payment of the lesser of the following:
 - 1) The number of months remaining in treatment times \$125 per month.
 - 2) \$3000 less any copayments (including start-up fees) paid prior to termination of this benefit.
- b) If a termination of benefits occurs due to a termination of the Group Subscriber Agreement, the group shall reserve the right to assign members residual obligation as described in (a) above to a successor organization.
- c) If member loses eligibility for 3 or more consecutive months they will be considered no longer eligible for orthodontic benefits, and (1) above would apply.
- d) Dependents other than spouse lose benefits on the 19th birthday (subject to 1 a & b above).

III. ADDITIONAL CHARGES

- a) Treatment that extends beyond 24 months will be subject to an office visit charge, which will be the members responsibility.
- b) The charge for each additional month will not exceed

\$125.00 per month.

IV. SERVICES NOT PROVIDED

The following are not benefits included as part of orthodontic services provided by Pacific Union Dental

- a) Start-up including:
 - 1. Cephalometric x-rays*
 - 2. Tracings*
 - 3. Study models*
 - 4. Photos*
- b) Lost or broken appliances.
- c) Retreatment of orthodontic cases.
- d) Treatment in progress at inception of eligibility.
- e) Changes in treatment necessitated by accident of any kind.
- f) Extraction of teeth or surgical procedures performed for orthodontic purposes.
- g) Replacement (including bridgework) or restoration (including crowns) of teeth caused solely by the orthodontic treatment.
- h) Orthodontics for TMJ problems including assessment beyond that customarily provided in general practice.
- i) Cases involving:
 - 1. Surgical orthodontics.
 - 2. Myofunctional therapy.
 - 3. Cleft palate.
 - 4. Micrognathia.
 - 5. Macroglossia.
 - 6. Hormonal imbalances.
 - 7. Phase I orthodontic care.
 - 8. Orthodontic care prior to age ten or after the age of nineteen.
- j) Transfer of Orthodontic provider for any reason in the middle of treatment.
- k) Orthodontic cases extending beyond the 19th birthday are subject to loss of benefit residual obligation provision (refer to SECTION II LOSS OF BENEFIT/RESIDUAL OBLIGATIONS).
- l) Any treatment rendered by any noncontracted Orthodontic provider.

* Start up fees subject to additional combined charge not to exceed \$350.00.