

SUMMARY OF PREPAID DENTAL BENEFITS

Group Best Choice

The following are covered benefits when provided by a participating CALIFORNIA DENTAL NETWORK general dentist:

*No Claim Forms! No Deductibles! No Annual Maximums! No Waiting Periods to See a Dentist!
No Limitations on Most Pre-Existing Conditions!*

	MEMBER COPAYMENT
<u>I. PREVENTIVE SERVICES</u>	
Office visit	\$5.00
Oral examination.....	NO CHARGE
Intra-oral x-rays, complete series.....	NO CHARGE
Bitewing x-ray, single film	NO CHARGE
Panoramic x-ray.....	NO CHARGE
Prophylaxis (cleaning).....	NO CHARGE
Topical fluoride (child).....	NO CHARGE
<u>II. ROUTINE SERVICES</u>	
<u>RESTORATIONS</u>	
Amalgam, one surface	\$10.00
Amalgam, two surfaces.....	\$15.00
Amalgam, three surfaces.....	\$20.00
Resin, up to three surfaces	\$25.00
<u>ORAL SURGERY</u>	
Extraction, single tooth.....	\$25.00
Surgical removal of erupted tooth.....	\$45.00
Removal of impacted tooth, soft tissue.....	\$60.00
<u>ENDODONTICS</u>	
Pulp cap, direct or indirect	\$15.00
Root canal, anterior.....	\$125.00
Root canal, bicuspid.....	\$150.00
Root canal, molar.....	\$185.00
<u>PERIODONTICS</u>	
Gingivectomy or gingivoplasty, per quadrant.....	\$150.00
Periodontal scaling and root planing, per quadrant	\$40.00
<u>III. MAJOR SERVICES</u>	
<u>CROWNS & BRIDGES</u>	
Crown, resin (laboratory)	\$145.00
Crown, resin with high noble metal*.....	\$175.00
Crown, porcelain fused to high noble metal* (not for molars)	\$275.00
Crown, porcelain fused to high noble metal* (for molars).....	\$350.00
Prefabricated stainless steel crown, primary tooth	\$50.00
Sedative filling.....	\$10.00
Re-cement bridge	\$25.00
*Member is responsible for copayment plus actual lab cost of gold.	
<u>PROSTHODONTICS</u>	
Complete upper or lower denture	\$350.00
Upper or lower partial denture, resin base.....	\$300.00
Removable unilateral partial denture, one piece cast metal (including clasps and pontics).....	\$350.00
Adjust denture.....	\$25.00
Repair broken complete denture base.....	\$50.00
Replace missing or broken teeth, complete denture, each tooth.....	\$25.00
Add tooth or clasp to existing partial denture.....	\$50.00
Reline complete or partial upper or lower denture (chair-side).....	\$65.00
Reline complete or partial upper or lower denture (laboratory).....	\$100.00
<u>IV. ORTHODONTICS</u>	
Full-banded case (upper and lower), to age 19	\$1,775.00
Full-banded case (upper and lower), adult	\$1,975.00
Upper or lower banded case.....	\$1,000.00
Consultation.....	\$25.00

Benefits are limited to services of a general dentist.

The ratio of premium costs to health services paid, for plan contracts with individuals and groups of 25 or fewer members, during the preceding fiscal year was 0%.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS

Plan 460

- (A) Deductibles. None
- (B) Lifetime maximums. None
- (C) Professional services.

Dental services are covered benefits when provided by a California Dental Network contracting Dentist

Member Services

<i>Preventive Service</i>		<i>Copayments</i>
	Office Visit	\$5.00
0120	Periodic Exams	No Charge
0210	X-rays	No Charge
1120	Cleanings	No Charge

<i>Routine Service</i>		<i>Copayments</i>
2140	Amalgam Fillings – One Surface	\$10.00
2150	Amalgam Fillings - Two Surface	\$15.00
2330	Resin Filling - One Surface	\$25.00
7110	Simple Extraction	\$25.00
7220	Surgical Extraction - tissue impacted	\$60.00
3310	Root Canal - Anterior Tooth	\$125.00

<i>Major Services</i>		<i>Copayments</i>
2710	Resin Crown (Laboratory)	\$145.00
2750	Porcelain Crown (PFM)	
	- Anterior tooth	\$275.00
	- Molars	\$350.00
5110/1	Complete denture - upper or lower	\$350.00
5213/4	Partial Denture - upper or lower	\$350.00

<i>Orthodontics (Upper & Lower) – Standard 24 Month Case</i>		<i>Copayments</i>
	Children to age 18	\$1,775.00
	Adults	\$1,995.00

- (D) Outpatient services. Not Covered
- (E) Hospitalization services. Not Covered
- (F) Emergency health coverage* \$50 per year
- (G) Ambulance services. Not Covered
- (H) Prescription drugs. Not Covered
- (I) Durable medical. Not Covered

Vision Plan of America

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| (J) Mental health services. | Not Covered |
| (K) Chemical dependency. | Not Covered |
| (L) Home health services. | Not Covered |

Other:

* Emergency services provided by California Dental Network contracting dentist for applicable co-payments. Members reimbursed for up to \$50.00 per year for out of are emergency dental care.