

SUMMARY OF PREPAID DENTAL BENEFITS

Dental 460 Plan

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!*

| <u>I. PREVENTIVE SERVICES</u> | MEMBER COPAYMENT |
|--|-----------------------------|
| 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

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

| <u>Routine Service</u> | <u>Copayments</u> |
|--|--------------------------|
| 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 |

| <u>Major Services</u> | <u>Copayments</u> |
|--|--------------------------|
| 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 |

| <u>Orthodontics (Upper & Lower) – Standard 24 Month Case</u> | <u>Copayments</u> |
|---|--------------------------|
| 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.