

2026 DENTAL GUIDE

Allowance - Calendar Year Maximum

Medicare Advantage Plan

Arizona

California

Nevada

New Mexico

Texas

DentaQuestTM
a Sun Life company



For California HMO plans: Dental benefits are provided by California Dental Network. California Dental Network does business as DentaQuest. Throughout this document, California Dental Network is referred to as DentaQuest

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INTRODUCTION

SCAN is excited to partner with DentaQuest to administer your supplemental dental benefits in 2026. This partnership is designed to give you access to quality care, a strong network of providers, and the helpful service you expect from SCAN Health Plan.

In this guide, you'll find everything you need to make the most of your dental coverage, including:

- Details about your plan premium and cost-sharing;
- A summary of your supplemental dental benefits;
- Steps for finding and receiving dental care;
- What to do if you have a concern or complaint; and
- Contact information for additional assistance.

The information in this guide applies to members enrolled in the SCAN Health Plans listed below from January 1 through December 31, 2026.

State	Plan Name	Counties
AZ	SCAN Balance (HMO C-SNP)	Maricopa / Pima / Pinal
AZ	SCAN Classic (HMO)	Maricopa / Pima / Pinal
AZ	SCAN Embrace (HMO-POS I-SNP)	Maricopa / Pima
AZ	SCAN Embrace Together (HMO-POS I-SNP)	Maricopa / Pima
AZ	SCAN Strive (HMO C-SNP)	Maricopa / Pima
CA	SCAN Affirm partnered with Included LGBTQ+ Health (HMO)	San Francisco
CA	SCAN Allied (HMO)	Los Angeles / San Francisco / San Mateo
CA	SCAN Balance (HMO C-SNP)	Alameda / Fresno / Kings / Madera / Placer / Sacramento / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Yolo
CA	SCAN Classic (HMO)	Alameda / Fresno / Kings / Madera / Placer / Sacramento / Santa Clara / San Francisco / San Joaquin / San Mateo Stanislaus / Tulare / Yolo
CA	SCAN Desert Choice (HMO)	Riverside
CA	SCAN Embrace Together (HMO I-SNP)	Los Angeles / Orange / San Bernardino
CA	SCAN Inspired by women for women (HMO)	Los Angeles / Orange
CA	SCAN Prime (HMO)	Los Angeles / Orange / San Bernardino
CA	SCAN Strive (HMO C-SNP)	Alameda / Fresno / Kings / Los Angeles / Madera / Orange / Placer / Riverside / Sacramento / San Bernardino / San Diego / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Ventura / Yolo
CA	VillageHealth (HMO-POS C-SNP)	Los Angeles / Riverside / San Bernardino
NV	SCAN Balance (HMO C-SNP)	Clark / Nye

State	Plan Name	Counties
NV	SCAN Classic (HMO)	Clark / Nye
NV	SCAN Strive (HMO C-SNP)	Clark
NM	SCAN Balance (HMO C-SNP)	Bernalillo / Sandoval
NM	SCAN Classic (HMO)	Bernalillo / Sandoval
NM	SCAN Strive (HMO C-SNP)	Bernalillo / Sandoval
TX	SCAN Balance Texas (HMO C-SNP)	Bexar / Fort Bend / Harris / Montgomery
TX	SCAN Classic Texas (HMO)	Bexar / Fort Bend / Harris / Montgomery
TX	SCAN Strive Texas (HMO C-SNP)	Bexar / Fort Bend / Harris / Montgomery

CONTACT US

For questions about this document or for assistance with claims and/or billing, please contact:

Method	Contact Information
WEBSITE	DentaQuest www.dentaquest.com SCAN Health Plan www.scanhealthplan.com
CALL	<p>DentaQuest 1-877-227-1625</p> <p>SCAN Health Plan</p> <p>California 1-800-559-3500</p> <p> Embrace/Embrace Together 1-855-828-7226</p> <p> VillageHealth..... 1-800-399-7226</p> <p>Arizona..... 1-855-650-7226</p> <p> Embrace/Embrace Together 1-855-828-7226</p> <p>New Mexico 1-855-826-7226</p> <p>Nevada 1-855-827-7226</p> <p>Texas 1-855-844-7226</p> <p>Calls to these numbers are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>Calls to this number are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p>

RECEIVING DENTAL CARE AND SERVICES

Membership Card (ID)

As a SCAN member, you will receive a plan membership card. Please show your SCAN membership card when receiving dental services. If you do not use your plan membership card, you may be asked to pay the full cost of dental services yourself. You will not receive a separate dental membership card.

If your plan membership card is damaged, lost, or stolen, call SCAN Member Services at the phone number listed within Contact Us - page 5 of this document and we will send you a new card.

Dental Provider Selection

You may obtain dental care and services from any dental provider of your choice. We strongly recommend that you use DentaQuest network providers to get your dental care and that you confirm the network participation status of your chosen dental office before receiving services.

In-Network / Network Providers

You may obtain dental care and services from any DentaQuest network provider of your choice.

Network providers have agreed to submit claims on your behalf and to accept our payment and any member cost-sharing as payment in full. For more information about how your benefits are applied and member cost-sharing, please refer to the 'Payment for Services' section.

Provider participation within the DentaQuest network may change at any time. Please confirm the network participation status of your chosen dental office before receiving services.

The most recent list of providers is available:

Method	Contact Information
WEBSITE	<p>DentaQuest</p> <ol style="list-style-type: none"> 1. Visit www.DentaQuest.com. 2. Input your location. 3. Within the drop-down menu: <ul style="list-style-type: none"> • Update Insurance Type to “Medicare” • Choose “SCAN Health Plan” 4. Click on “Find A Dentist”. <p>The provider directory does not serve as a recommendation of any dental provider and does not guarantee that providers listed are accepting new members.</p>
CALL	<p>DentaQuest</p> <p>1-877-227-1625</p> <p>Calls to this number are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p>
TTY	<p>711</p> <p>Calls to this number are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p>

Out-of-Network Providers

Out-of-network providers may not submit claims on your behalf. You may be required to pay upfront and submit for reimbursement. For reimbursement instructions, please refer to the ‘Claims Reimbursement’ section.

Out-of-network providers have not agreed to accept the plan’s allowed amount and may collect their billed amount. The difference between their billed amount and the plan’s allowed amount is known as balance billing. You are responsible for paying this amount in addition to any applicable member cost-sharing. For additional details, please refer to the ‘Payment for Services’ section.

Payment for Services

Payment to providers is subject to applicable Calendar Year Benefit Maximums, limitations, exclusions, and/or processing policies such as coordination of benefits. Payment to providers and member cost-sharing may vary based upon the network participation status of the Treating Dentist.

To confirm your coverage details, including the network participation status of your dentist, please obtain a prior authorization before receiving services.

For an overview of benefits when services are obtained at an in-network provider versus an out-of-network provider, please see below:

Benefit Example

		In-Network	Out-of-Network
Dentist Billed Amount	Amount dentist charges.	\$1,000	\$1,000
Allowed Amount	Amount DentaQuest agrees to pay (in-network contracted amount).	\$500	\$500
Member Cost-Share	Member's copay or coinsurance amount up to the calendar year benefit maximum.	\$0	50%
Plan Payment	Amount paid to the dental office.	\$500	\$250
Member Payment	Member's total financial responsibility determined by the sum of:	\$0	\$750
	Plan Allowed Amount x Member Cost-Share	\$0	\$250
	Out-of-Network Dentist Billed Amount – Plan Allowed Amount	\$0	\$500

If you have questions about your financial responsibility listed on your invoice and/or explanation of benefit, please contact your dental office or DentaQuest's Customer Service to confirm the charges.

Prior Authorization

Payment to providers is subject to applicable Calendar Year Benefit Maximums, limitations, exclusions, and/or processing policies such as coordination of benefits and prior authorization requirements.

To confirm your coverage details, including the network participation status of your dentist, prior authorization may be required.

If you have questions about your coverage decision and/or financial responsibility listed on your invoice and/or explanation of benefit, please contact your dental office or DentaQuest's Customer Service to confirm the charges.

Optional Services

Optional Services refers to dental treatment that exceeds professionally recognized standards of necessity and may involve specialized techniques, higher-cost materials, and/or more extensive procedures than clinically required.

If a member receives optional services, the plan will consider the more conservative treatment. The member is responsible for the difference between the cost of the optional service and the alternative treatment, in addition to any applicable member cost-sharing.

Second Opinion

You have the right to request a second opinion about your care if you disagree with the opinion of your network provider or you wish for confirmation of a diagnosis, medical necessity or the appropriateness of a treatment or procedure. If you wish to request a second medical opinion, simply contact your network provider. Please note that plan covered services, limitations, and restrictions apply and any charges for non-covered services will be member responsibility.

Emergency Services

What is a dental emergency and what should you do if you have one?

A dental emergency is when you have a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result in either: placing your dental health in serious jeopardy or serious impairment to dental functions.

If you have a dental emergency, take the following steps:

1. Contact your network dental provider.
2. Contact Customer Service at DentaQuest. If you have not established care or your network dental provider is unavailable contact DentaQuest's customer service at 1-877-227-1625 (TTY 711), 7 days a week from October 1 to March 31, 8 a.m. to 8 p.m. and Monday through Friday from April 1 to September 30, 8 a.m. to 8 p.m., for help in locating a network provider.
3. Notify SCAN Health Plan.

If care is obtained from an out-of-network provider:

- Members must first attempt to access services through an in-network provider by following the steps outlined above.
- Coverage is limited to dental procedures included within the 'Schedule of Dental Benefits' which stabilize your condition and/or provide palliative relief.
- Benefit terms, limitations, and restrictions remain applicable.
- As soon as your condition and the circumstances allow, care should be taken over by a network provider.

COMPLAINTS & APPEALS

If you have a problem or concern regarding your benefits, coverage, quality of dental services performed by a network dental provider, or other, you have the right to file a complaint or appeal with SCAN Health Plan. For more information on making a complaint or appeal, please refer to the SCAN Health Plan Evidence of Coverage and/or contact:

Method	Complaints & Appeals For Dental Care - Contact Information
CALL	<p>SCAN Health Plan</p> <p>California 1-800-559-3500</p> <p>Arizona 1-855-650-7226</p> <p>New Mexico 1-855-826-7226</p> <p>Nevada 1-855-827-7226</p> <p>Texas 1-855-844-7226</p> <p>VillageHealth 1-800-399-7226</p> <p>Calls to these numbers are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>Calls to this number are free.</p> <p>Contact us October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday.</p> <p>Note: We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received on holidays and outside of our business hours will be returned within one business day.</p>
FAX	1-562-989-0958
WRITE	<p>SCAN Health Plan Attention: Grievance and Appeals Department P.O. Box 22644 Long Beach, CA 90801-5644</p>

PLANS

State	Plan Name	Counties	Calendar Year Maximum
AZ	SCAN Balance (HMO C-SNP)	Maricopa / Pima / Pinal	\$3,000
AZ	SCAN Classic (HMO)	Maricopa / Pima / Pinal	\$3,000
AZ	SCAN Embrace (HMO-POS I-SNP)	Maricopa / Pima	\$3,000
AZ	SCAN Embrace Together (HMO-POS I-SNP)	Maricopa / Pima	\$2,500
AZ	SCAN Strive (HMO C-SNP)	Maricopa / Pima	\$4,000
CA	SCAN Affirm partnered with Included LGBTQ+ Health (HMO)	San Francisco	\$2,000
CA	SCAN Allied (HMO)	Los Angeles / San Francisco / San Mateo	\$2,500
CA	SCAN Balance (HMO C-SNP)	Alameda / Fresno / Kings / Madera / Placer / Sacramento / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Yolo	\$3,000
CA	SCAN Classic (HMO)	Alameda / Fresno / Kings / Madera / Placer / Sacramento / Santa Clara / San Francisco / San Joaquin / San Mateo / Stanislaus / Tulare / Yolo	\$3,000
CA	SCAN Desert Choice (HMO)	Riverside	\$4,000
CA	SCAN Embrace Together (HMO I-SNP)	Los Angeles / Orange / San Bernardino	\$3,000
CA	SCAN Inspired by women for women (HMO)	Los Angeles / Orange	\$3,000
CA	SCAN Prime (HMO)	Los Angeles / Orange / San Bernardino	\$4,000
CA	SCAN Strive (HMO C-SNP)	Alameda / Fresno / Kings / Los Angeles / Madera / Orange / Placer / Riverside / Sacramento / San Bernardino / San Diego / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Ventura / Yolo	\$4,000
CA	VillageHealth (HMO-POS C-SNP)	Los Angeles / Riverside / San Bernardino	\$2,000
NV	SCAN Balance (HMO C-SNP)	Clark / Nye	\$3,000
NV	SCAN Classic (HMO)	Clark / Nye	\$3,000
NV	SCAN Strive (HMO C-SNP)	Clark	\$4,000

State	Plan Name	Counties	Calendar Year Maximum
NM	SCAN Balance (HMO C-SNP)	Bernalillo / Sandoval	\$3,000
NM	SCAN Classic (HMO)	Bernalillo / Sandoval	\$3,000
NM	SCAN Strive (HMO C-SNP)	Bernalillo / Sandoval	\$4,000
TX	SCAN Balance Texas (HMO C-SNP)	Bexar / Fort Bend / Harris / Montgomery	\$3,500
TX	SCAN Classic Texas (HMO)	Bexar / Fort Bend / Harris / Montgomery	\$3,500
TX	SCAN Strive Texas (HMO C-SNP)	Bexar / Fort Bend / Harris / Montgomery	\$4,000

BENEFIT CONDITIONS, LIMITATIONS, AND EXCLUSIONS

Conditions

Calendar Year Benefit Maximum

- A. Plan payment for comprehensive dental services apply toward the Calendar Year Benefit Maximum.
- B. Member is responsible for any charges once the Calendar Year Benefit Maximum has been used in full.
- C. Any unused portion of the Calendar Year Benefit Maximum remaining at the end of the calendar year will expire.

Non-Covered Services

This plan does not provide coverage for all dental procedure codes. Any dental procedure code which is not listed within the 'Schedule of Dental Benefits' is not covered and will be the member's financial responsibility.

Member Cost-Sharing

- A. Member cost-share applies to the allowable amount of the procedure code. *Member cost-share may vary if services are completed by an out-of-network provider and your out-of-pocket costs may be higher. For more information, please refer to the 'Payment for Services' section.
- B. Out-of-pocket expenses related to the receipt of supplemental dental services do not count toward your maximum out-of-pocket amount.
- C. If you have other insurance, the Coordination of Benefit rules outlined within the SCAN Health Plan Evidence of Coverage may apply.

Limitations

- **Eligibility.** Eligibility for plan covered services is subject to the frequency limitations listed with the 'Schedule of Dental Benefits'. Unless noted, eligibility is determined from the last date(s) of service in which treatment was completed.
- **Multi-Stage Treatment.** When treatment takes place over the course of many steps and/or appointments, the date of service is defined as the date in which the service is completed or delivered. For example, crowns = seat date, root canal = completion date, and bridges/dentures = delivery date.
- **Radiographic Images.** Reimbursement for all eligible radiographic images taken on the same date of service, regardless of procedure code combination, will be limited to the allowable amount for a comprehensive intraoral series.
- **Non-Payable / Non-Allowable.** Enforcement of non-payable and/or non-allowance conjunctive procedures is limited to completion of services by a network provider who has agreed to contractual administrative provisions. Member is responsible for any associated charges if the service is completed by an out-of-network dental provider.

Exclusions

Benefits are not considered for:

- Any dental procedure which is not listed within the 'Schedule of Dental Benefits'.
- Services which are cosmetic in nature and/or completed for cosmetic purposes.
- Any dental service which requires prior authorization and has not been approved through the prior authorization process.
- Services performed prior to the member's effective date.
- Services completed after the member's termination date and/or the conclusion of the calendar year, December 31st, 2026.
- Procedures having questionable / poor prognosis as determined by professional review.
- Charges associated with incomplete, temporary, and/or interim services.
- Orthodontic treatment.
- Services to address temporomandibular joints (TMJ) and/or associated musculature.
- Treatment for congenital or developmental malformations including but not limited to cleft palate, jaw malformations.
- Experimental procedures as determined by professional review.
- Charges assessed by a hospital and/or facility
- Services associated with dental practice administration (e.g. x-ray duplication, missed/cancelled appointments, appt. reminders, claim preparation, equipment sterilization, etc.) rather than direct patient clinical care.
- Dental splints.
- Lost or stolen appliances.
- Prescribed drugs, medication (including toothpaste), and/or antimicrobial agents.

SCHEDULE OF DENTAL BENEFITS

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D0120	periodic oral evaluation - established patient	Two (D0120, D0160, D0170) every 12 months, per member.	0%	0%	No
D0140	limited oral evaluation-problem focused	Three per 12 months, per member. Not payable with routine services	0%	0%	No
D0150	comprehensive oral evaluation - new or established patient	One of (D0150, D0180) every 36 months, per provider or location. One of (D0120, D0150, D0180) per 6 months, per provider or location.	0%	0%	No
D0160	detailed and extensive oral eval-problem focused, by report	Two (D0120, D0160, D0170) every 12 months, per member.	0%	0%	No
D0170	re-evaluation, limited problem focused		0%	0%	No
D0180	comprehensive periodontal evaluation - new or established patient	One of (D0150, D0180) every 36 months, per provider or location. One of (D0120, D0150, D0180) per 6 months, per provider or location.	0%	0%	No
D0210	intraoral- comprehensive series of radiographic images	One of (D0210, D0330, D0277, D0372) every 36 months, per member.	0%	0%	No
D0220	intraoral - periapical first radiographic image		0%	0%	No
D0230	intraoral - periapical each additional radiographic image		0%	0%	No
D0240	intraoral - occlusal radiographic image	Two per 24 months, per member.	0%	0%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D0270	bitewing - single radiographic image	One of (D0270, D0272, D0273, D0274, D0373) every 12 months, per member.	0%	0%	No
D0272	bitewings - two radiographic images		0%	0%	No
D0273	bitewings - three radiographic images		0%	0%	No
D0274	bitewings - four radiographic images		0%	0%	No
D0277	vertical bitewings - 7 to 8 films	One of (D0210, D0330, D0277, D0372) every 36 months, per member.	0%	0%	No
D0330	panoramic radiographic image		0%	0%	No
D0372	intraoral tomosynthesis – comprehensive series of radiographic images		0%	0%	No
D0373	intraoral tomosynthesis – bitewing radiographic image	One of (D0270, D0272, D0273, D0274, D0373) every 12 months, per member.	0%	0%	No
D0374	intraoral tomosynthesis – periapical radiographic image	One of (D0374) every 12 months, per member.	0%	0%	No
D1110	prophylaxis - adult	Two of (D1110, D4346, D4910) every 12 months, per member.	0%	0%	No
D1206	topical application of fluoride varnish	Two of (D1206, D1208, D9910) per 12 months, per member.	0%	0%	No
D1208	topical application of fluoride - excluding varnish		0%	0%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D2140	amalgam - one surface, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990), one restoration per tooth, per surface, once in 24 months, per member. D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid not allowed.	0%	50%	No
D2150	amalgam - two surfaces, primary or permanent		0%	50%	No
D2160	amalgam - three surfaces, primary or permanent		0%	50%	No
D2161	amalgam - four or more surfaces, primary or permanent		0%	50%	No
D2330	resin-based composite - one surface, anterior		0%	50%	No
D2331	resin-based composite - two surfaces, anterior		0%	50%	No
D2332	resin-based composite - three surfaces, anterior		0%	50%	No
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)		0%	50%	No
D2390	resin-based composite crown, anterior		0%	50%	No
D2391	resin-based composite - one surface, posterior		0%	50%	No
D2392	resin-based composite - two surfaces, posterior		0%	50%	No
D2393	resin-based composite - three surfaces, posterior		0%	50%	No
D2394	resin-based composite - four or more surfaces, posterior		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D2510	inlay - metallic -1 surface	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794), once per tooth, per 60 months, per member.	0%	50%	Yes
D2520	inlay-metallic-2 surfaces		0%	50%	Yes
D2530	inlay-metallic-3+ surfaces		0%	50%	Yes
D2542	onlay - metallic - two surfaces		0%	50%	Yes
D2543	onlay-metallic-3 surfaces		0%	50%	Yes
D2544	onlay-metallic-4+ surfaces		0%	50%	Yes
D2610	inlay-porce/ceramic-1surface		0%	50%	Yes
D2620	inlay-porcelain/ceramic-2 surfaces		0%	50%	Yes
D2630	inlay-porc/ceramic 3+ surfaces		0%	50%	Yes
D2642	onlay-porcelain/ceramic-2 surfaces		0%	50%	Yes
D2643	onlay-porcelain/ceramic-3 surfaces		0%	50%	Yes
D2644	onlay-porcelain/ceramic-4+ surfaces		0%	50%	Yes
D2650	inlay-composite/resin 1surface		0%	50%	Yes
D2651	inlay-composite/resin-2 surfaces		0%	50%	Yes
D2652	inlay-composite/resin-3+ surfaces		0%	50%	Yes
D2662	onlay-composite/resin-2 surfaces		0%	50%	Yes
D2663	onlay-composite/resin-3 surfaces		0%	50%	Yes
D2664	onlay-composite/resin-4+ surfaces		0%	50%	Yes
D2710	crown - resin-based composite (indirect)		0%	50%	Yes
D2712	crown - 3/4 resin-based composite (indirect)		0%	50%	Yes
D2720	crown-resin with high noble metal	0%	50%	Yes	

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D2721	crown - resin with predominantly base metal	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794), once per tooth, per 60 months, per member.	0%	50%	Yes
D2722	crown - resin with noble metal		0%	50%	Yes
D2740	crown - porcelain/ceramic		0%	50%	Yes
D2750	crown - porcelain fused to high noble metal		0%	50%	Yes
D2751	crown - porcelain fused to predominantly base metal		0%	50%	Yes
D2752	crown - porcelain fused to noble metal		0%	50%	Yes
D2753	crown-porcelain fused to titanium and titanium alloys		0%	50%	Yes
D2780	crown - ¾ cast high noble metal		0%	50%	Yes
D2781	crown - ¾ cast predominantly base metal		0%	50%	Yes
D2782	crown - ¾ cast noble metal		0%	50%	Yes
D2783	crown - ¾ porcelain/ceramic		0%	50%	Yes
D2790	crown - full cast high noble metal		0%	50%	Yes
D2791	crown - full cast predominantly base metal		0%	50%	Yes
D2792	crown - full cast noble metal		0%	50%	Yes
D2794	crown - titanium		0%	50%	Yes
D2799	provisional crown	0%	50%	No	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Once per tooth per 24 months (after 6 months have elapsed since initial placement).	0%	50%	No
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		0%	50%	No
D2920	re-cement or re-bond crown		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D2940	placement of interim direct restoration	Once per tooth per lifetime.	0%	50%	No
D2950	core buildup, including any pins when required	One of (D2950, D2951, D2952, D2953, D2954) once per tooth per 60 months, per member. Deny when billed with resin or amalgam restoration. D2951 is not allowed with D2950, D2952, D2954.	0%	50%	No
D2951	pin retention - per tooth, in addition to restoration		0%	50%	No
D2952	cast post and core in addition to crown		0%	50%	No
D2953	each additional cast post - same tooth		0%	50%	No
D2954	prefabricated post and core in addition to crown		0%	50%	No
D2980	crown repair, by report	Once per tooth per 24 months (after 6 months have elapsed since initial placement).	0%	50%	No
D2990	resin infiltration of incipient smooth surface lesions	One restoration (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per tooth, per surface, per 24 months per member.	0%	50%	No
D2999	unspecified restorative procedure, by report		0%	50%	Yes
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	One of (D3220 or D3221) once per tooth, per lifetime, per member. Not payable in conjunction with root canal therapy by same provider/ location within 90 days.	0%	50%	No
D3221	pulpal debridement, primary and permanent teeth		0%	50%	No
D3310	endodontic therapy, anterior tooth (excluding final restoration)	Once per permanent tooth per lifetime.	0%	50%	No
D3320	endodontic therapy, premolar tooth (excluding final restoration)		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D3330	endodontic therapy, molar tooth (excluding final restoration)	Once per permanent tooth per lifetime.	0%	50%	No
D3331	treatment of root canal obstruction; non-surgical access		0%	50%	No
D3346	retreatment of previous root canal therapy- anterior		0%	50%	No
D3347	retreatment of previous root canal therapy - premolar		0%	50%	No
D3348	retreatment of previous root canal therapy-molar		0%	50%	No
D3410	apicoectomy - anterior		0%	50%	Yes
D3421	apicoectomy - premolar (first root)		0%	50%	Yes
D3425	apicoectomy - molar (first root)		0%	50%	Yes
D3426	apicoectomy (each additional root)		0%	50%	Yes
D3430	retrograde filling - per root		0%	50%	Yes
D3999	unspecified endodontic procedure, by report		0%	50%	Yes
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4210, D4211) once per quadrant per 36 months, per member.	0%	50%	Yes
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant		0%	50%	Yes
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4240, D4241) once per quadrant per 36 months, per member.	0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	One of (D4240, D4241) once per quadrant per 36 months, per member.	0%	50%	Yes
D4249	clinical crown lengthening - hard tissue	Once per permanent tooth per lifetime.	0%	50%	Yes
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4260 or D4261), once per quadrant per 36 months, per member.	0%	50%	Yes
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant		0%	50%	Yes
D4341	periodontal scaling and root planing - four or more teeth per quadrant	One of (D4341 or D4342), once per quadrant per 36 months, per member.	0%	50%	Yes
D4342	periodontal scaling and root planing - one to three teeth per quadrant		0%	50%	No
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Two of (D1110, D4346, D4910) every 12 months, per member.	0%	50%	No
D4355	full mouth debridement to enable a comprehensive oral periodontal evaluation and diagnosis on a subsequent visit	One per 36 months, per member.	0%	50%	No
D4910	periodontal maintenance procedures	Four of D4910 every 12 months, per member.	0%	50%	No
D4999	unspecified periodontal procedure, by report		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D5110	complete denture - maxillary	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227, D5863, D5864, D6110, D6112), once per 60 months, per member. One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228, D5865, D5866, D6111, D6113), once per 60 months, per member.	0%	50%	No
D5120	complete denture - mandibular		0%	50%	No
D5130	immediate denture - maxillary		0%	50%	No
D5140	immediate denture - mandibular		0%	50%	No
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		0%	50%	No
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		0%	50%	No
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0%	50%	No
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0%	50%	No
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		0%	50%	No
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		0%	50%	No
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0%	50%	No	

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227, D5863, D5864, D6110, D6112), once per 60 months, per member.	0%	50%	No
D5225	maxillary partial denture-flexible base		0%	50%	No
D5226	mandibular partial denture-flexible base		0%	50%	No
D5227	immediate maxillary partial denture-flexible base		0%	50%	No
D5228	immediate mandibular partial denture-flexible base		0%	50%	No
D5410	adjust complete denture - maxillary	Two adjustments per arch per 12 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5411	adjust complete denture - mandibular		0%	50%	No
D5421	adjust partial denture-maxillary		0%	50%	No
D5422	adjust partial denture - mandibular		0%	50%	No
D5511	repair broken complete denture base, mandibular	Once per arch per 12 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5512	repair broken complete denture base, maxillary		0%	50%	No
D5520	replace missing or broken teeth - complete denture - per tooth		0%	50%	No
D5611	repair resin denture base, mandibular		0%	50%	No
D5612	repair resin denture base, maxillary	Once per arch per 12 months.	0%	50%	No
D5621	repair cast framework, mandibular		0%	50%	No
D5622	repair cast framework, maxillary		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D5630	repair or replace broken clasp	Once per tooth per 12 months, per member.	0%	50%	No
D5640	replace missing or broken teeth – partial denture – per tooth		0%	50%	No
D5650	add tooth to existing partial denture – per tooth		0%	50%	No
D5660	add clasp to existing partial denture		0%	50%	No
D5710	rebase complete maxillary denture	One of (D5710, D5730, D5750) per 36 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5711	rebase complete mandibular denture		0%	50%	No
D5720	rebase maxillary partial denture	One of (D5711, D5731, D5751) per 36 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5721	rebase mandibular partial denture		0%	50%	No
D5725	rebase of hybrid prosthesis		0%	50%	No
D5730	reline complete maxillary denture (chairside)		0%	50%	No
D5731	reline complete mandibular denture (chairside)	One of (D5720, D5740, D5760) per 36 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5740	reline maxillary partial denture (chairside)		0%	50%	No
D5741	reline mandibular partial denture (chairside)	One of (D5721, D5741, D5761) per 36 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5750	reline complete maxillary denture (laboratory)		0%	50%	No
D5751	reline complete mandibular denture (laboratory)		0%	50%	No
D5760	reline maxillary partial denture (laboratory)		0%	50%	No
D5761	reline mandibular partial denture (laboratory)	One of D5765 per arch per 36 months (after 6 months have elapsed since initial placement).	0%	50%	No
D5765	soft liner for complete or partial dentures (indirect)		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D5850	tissue conditioning, maxillary	Only allowed in conjunction with fabrication of new denture. Not allowed for 60 months after delivery of new denture.	0%	50%	No
D5851	tissue conditioning, mandibular		0%	50%	No
D5863	overdenture - complete maxillary	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227, D5863, D5864), once per 60 months, per member.	0%	50%	No
D5864	overdenture - partial maxillary		0%	50%	No
D5865	overdenture - complete mandibular		0%	50%	No
D5866	overdenture - partial mandibular	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228, D5865, D5866), once per 60 months, per member.	0%	50%	No
D5876	add metal substructure to acrylic full denture	Only allowed on the same date of service as D5110, D5120, D5130, D5140.	0%	50%	No
D5899	unspecified removable prosthodontic procedure, by report		0%	50%	Yes
D5999	unspecified maxillofacial prosthesis, by report		0%	50%	Yes
D6010	surgical placement of implant body: endosteal implant	One of (D6010, D6013) per 60 months, per tooth, per member.	0%	50%	Yes
D6013	surgical placement of mini implant		0%	50%	Yes
D6056	prefabricated abutment – includes modification and placement	One of (D6056, D6057) per 60 months, per tooth, per member.	0%	50%	Yes
D6057	custom fabricated abutment – includes placement		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6058	abutment supported porcelain/ceramic crown	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 months, per tooth, per member. Once per tooth per 24 months only after 6 months of initial placement (only after 6 months of initial placement).	0%	50%	Yes
D6059	abutment supported porcelain fused to metal crown (high noble metal)		0%	50%	Yes
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)		0%	50%	Yes
D6061	abutment supported porcelain fused to metal crown (noble metal)		0%	50%	Yes
D6062	abutment supported cast metal crown (high noble metal)		0%	50%	Yes
D6063	abutment supported cast metal crown (predominantly base metal)		0%	50%	Yes
D6064	abutment supported cast metal crown (noble metal)		0%	50%	Yes
D6065	implant supported porcelain/ceramic crown		0%	50%	Yes
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)		0%	50%	Yes
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)		0%	50%	Yes
D6068	abutment supported retainer for porcelain/ceramic FPD		0%	50%	Yes
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)		0%	50%	Yes
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	See limitations on page 27.	0%	50%	Yes
D6072	abutment supported retainer for cast metal FPD (high noble metal)		0%	50%	Yes
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)		0%	50%	Yes
D6074	abutment supported retainer for cast metal FPD (noble metal)		0%	50%	Yes
D6075	implant supported retainer for ceramic FPD		0%	50%	Yes
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)		0%	50%	Yes
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)		0%	50%	Yes
D6082	implant supported crown-porcelain fused to predominatly base alloys		0%	50%	Yes
D6083	implant supported crown-porcelain fused to noble alloys		0%	50%	Yes
D6084	implant supported crown-porcelain fused to titanium and titanium alloys		0%	50%	Yes
D6086	implant supported crown-predominatly base alloys		0%	50%	Yes
D6087	implant supported crown-noble alloys		0%	50%	Yes
D6088	implant supported crown titanium and titanium alloys		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6090	repair of implant/abutment supported prosthesis	See limitations on page 27.	0%	50%	No
D6091	replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		0%	50%	No
D6092	re-cement or re-bond implant/abutment supported crown		0%	50%	No
D6093	re-cement or re-bond implant/abutment supported fixed partial denture		0%	50%	No
D6094	abutment supported crown - (titanium)		0%	50%	Yes
D6097	abutment supported crown, porcelain fused to titanium and titanium alloys		0%	50%	Yes
D6098	implant supported retainer-porcelain fused to predominately base alloys		0%	50%	Yes
D6099	implant supported retainer for FPD-porcelain fused to noble alloys		0%	50%	Yes
D6106	guided tissue regeneration – resorbable barrier, per implant		One of (D6106, D6107, D7956, D7957) per 60 months, per tooth, per member.	0%	50%
D6107	guided tissue regeneration – non-resorbable barrier, per implant	0%		50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227, D5863, D5864, D6110, D6112), once per 60 months, per member. One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228, D5865, D5866, D6111, D6113), once per 60 months, per member.	0%	50%	No
D6111	implant /abutment supported removable denture for edentulous arch – mandibular		0%	50%	No
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary		0%	50%	No
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular		0%	50%	No
D6120	implant supported retainer-porcelain fused to titanium and titanium alloys	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 months, per tooth, per member.	0%	50%	Yes
D6121	implant supported retainer for metal FPD- predominately base alloys		0%	50%	Yes
D6122	implant supported retainer for metal FPD- noble alloys		0%	50%	Yes
D6123	implant supported retainer for metal FPD-titanium and titanium alloys		0%	50%	Yes
D6191	semi-precision abutment – placement		0%	50%	Yes
D6192	semi-precision attachment – placement	0%	50%	Yes	

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6195	abutment supported retainer-porcelain fused to titanium and titanium alloys	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 months, per tooth, per member.	0%	50%	Yes
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	One of (D6197) per 12 months, per tooth, per member.	0%	50%	No
D6205	pontic - indirect resin based composite	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per tooth per 60 months, per member.	0%	50%	Yes
D6210	pontic - cast high noble metal		0%	50%	Yes
D6211	pontic-cast base metal		0%	50%	Yes
D6212	pontic - cast noble metal		0%	50%	Yes
D6214	pontic - titanium		0%	50%	Yes
D6240	pontic-porcelain fused-high noble		0%	50%	Yes
D6241	pontic-porcelain fused to base metal		0%	50%	Yes
D6242	pontic-porcelain fused-noble metal		0%	50%	Yes
D6243	pontic-porcelain fused to titanium and titanium alloys		0%	50%	Yes
D6245	prosthodontics fixed, pontic - porcelain/ceramic		0%	50%	Yes
D6250	pontic-resin with high noble metal		0%	50%	Yes
D6251	pontic-resin with base metal		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6252	pontic-resin with noble metal	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per tooth, per 60 months, per member.	0%	50%	Yes
D6545	retainer - cast metal fixed	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794), per tooth, per 60 months, per member.	0%	50%	Yes
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic		0%	50%	Yes
D6549	resin retainer-For resin bonded fixed prosthesis		0%	50%	Yes
D6602	inlay - cast high noble metal, two surfaces		0%	50%	Yes
D6603	inlay - cast high noble metal, three or more surfaces		0%	50%	Yes
D6604	inlay - cast predominantly base metal, two surfaces		0%	50%	Yes
D6605	inlay - cast predominantly base metal, three or more surfaces		0%	50%	Yes
D6606	inlay - cast noble metal, two surfaces		0%	50%	Yes
D6607	inlay - cast noble metal, three or more surfaces		0%	50%	Yes
D6608	onlay - porcelain/ceramic, two surfaces		0%	50%	Yes
D6609	onlay - porcelain/ceramic, three or more surfaces		0%	50%	Yes
D6610	onlay - cast high noble metal, two surfaces		0%	50%	Yes
D6611	onlay - cast high noble metal, three or more surfaces		0%	50%	Yes
D6612	onlay - cast predominantly base metal, two surfaces		0%	50%	Yes
D6613	onlay - cast predominantly base metal, three or more surfaces		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6614	onlay - cast noble metal, two surfaces	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794), per tooth, per 60 months, per member.	0%	50%	Yes
D6615	onlay - cast noble metal, three or more surfaces		0%	50%	Yes
D6624	inlay - titanium		0%	50%	Yes
D6634	onlay - titanium		0%	50%	Yes
D6710	crown - indirect resin based composite		0%	50%	Yes
D6720	crown-resin with high noble metal		0%	50%	Yes
D6721	crown-resin with base metal		0%	50%	Yes
D6722	crown-resin with noble metal		0%	50%	Yes
D6740	retainer crown – porcelain/ceramic		0%	50%	Yes
D6750	crown-porcelain fused high noble		0%	50%	Yes
D6751	crown-porcelain fused to base metal		0%	50%	Yes
D6752	crown-porcelain fused noble metal		0%	50%	Yes
D6753	retainer crown-porcelain fused to titanium and titanium alloys		0%	50%	Yes
D6780	crown-3/4 cst high noble metal		0%	50%	Yes
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal		0%	50%	Yes
D6782	prosthodontics fixed, crown ¾ cast noble metal		0%	50%	Yes
D6784	retainer crown-3/4-titanium and titanium alloys		0%	50%	Yes
D6790	crown-full cast high noble		0%	50%	Yes
D6791	crown - full cast base metal		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D6792	crown - full cast noble metal	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794), per tooth, per 60 months, per member.	0%	50%	Yes
D6793	provisional retainer crown		0%	50%	Yes
D6794	crown - titanium		0%	50%	Yes
D6930	re-cement or re-bond fixed partial denture	Once per 24 months, per member. (Only after 6 months of initial placement.)	0%	50%	No
D6980	fixed partial denture repair		0%	50%	No
D6999	fixed prosthodontic procedure		0%	50%	Yes
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Once per tooth, per lifetime, per member.	0%	50%	No
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		0%	50%	Yes
D7220	removal of impacted tooth-soft tissue		0%	50%	No
D7230	removal of impacted tooth-partially bony		0%	50%	No
D7240	removal of impacted tooth-completely bony		0%	50%	No
D7241	removal of impacted tooth-completely bony, with unusual surgical complications		0%	50%	No
D7250	surgical removal of residual tooth roots (cutting procedure)		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D7251	coronectomy-intentional partial tooth removal, impacted teeth only	Once per tooth, per lifetime, per member.	0%	50%	Yes
D7252	partial extraction for immediate implant placement		0%	50%	Yes
D7259	nerve dissection		0%	50%	Yes
D7260	oroantral fistula closure	Two per arch, per lifetime, per member.	0%	50%	No
D7261	primary closure of a sinus perforation		0%	50%	No
D7284	excisional biopsy of minor salivary glands		0%	50%	Yes
D7285	incisional biopsy of oral tissue-hard (bone, tooth)		0%	50%	No
D7286	incisional biopsy of oral tissue-soft		0%	50%	No
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	One of (D7310 or D7311) per quadrant, per lifetime, per member.	0%	50%	No
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		0%	50%	No
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	One of (D7320 or D7321) per quadrant, per lifetime, per member.	0%	50%	No
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		0%	50%	No
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	One per arch, per lifetime, per member.	0%	50%	No
D7350	vestibuloplasty - ridge extension		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D7410	radical excision - lesion diameter up to 1.25cm		0%	50%	Yes
D7411	excision of benign lesion greater than 1.25 cm		0%	50%	Yes
D7440	excision of malignant tumor - lesion diameter up to 1.25cm		0%	50%	Yes
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm		0%	50%	Yes
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm		0%	50%	Yes
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm		0%	50%	Yes
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		0%	50%	Yes
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm		0%	50%	Yes
D7471	removal of exostosis - per site	Two per arch, per lifetime, per member, regardless of the provider.	0%	50%	Yes
D7472	removal of torus palatinus	Once per lifetime, per member, regardless of provider.	0%	50%	Yes
D7473	removal of torus mandibularis	Two per lifetime, per member, regardless of provider.	0%	50%	Yes
D7485	surgical reduction of osseous tuberosity		0%	50%	Yes
D7510	incision and drainage of abscess - intraoral soft tissue	Not payable in conjunction with extraction on same date of service.	0%	50%	No
D7520	incision and drainage of abscess - extraoral soft tissue		0%	50%	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		0%	50%	No
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	One of (D6106, D6107, D7956, D7957) per 60 months, per tooth, per member.	0%	50%	Yes
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site		0%	50%	Yes
D7961	buccal / labial frenectomy (frenulectomy)	Once per arch, per lifetime, per member.	0%	50%	No
D7962	lingual frenectomy (frenulectomy)		0%	50%	No
D7963	frenuloplasty		0%	50%	No
D7970	excision of hyperplastic tissue - per arch		0%	50%	No
D7971	excision of pericoronal gingiva		0%	50%	No
D7999	unspecified oral surgery procedure, by report		0%	50%	Yes
D9110	palliative treatment of dental pain -per visit	Not payable with anything other than D0140 and x-rays.	0%	50%	No
D9222	deep Sedation/general anesthesia-first 15 minutes	One per member per date of service. Not payable with (D9222, D9223, D9239, D9243, D9248) on the same day.	0%	50%	Yes
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment		0%	50%	Yes
D9230	inhalation of nitrous oxide/ analgesia, anxiolysis		0%	50%	Yes
D9239	intravenous moderation (conscious)		0%	50%	Yes
D9243	intravenous moderation (conscious)-each subsequent 15 minute increment		0%	50%	Yes

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D9248	non-intravenous moderate (conscious) sedation	One per member per date of service. Not payable with (D9222, D9223, D9239, D9243, D9248) on the same day.	0%	50%	Yes
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	One per provider or location per year. Not payable with (D0120, D0140, D0150, D0160, D0170, D0180) by same provider or location.	0%	50%	No
D9410	house/extended care facility call	One per date of service. Six per 12 months, per member.	0%	50%	No
D9420	hospital or ambulatory surgical center call		0%	50%	No
D9910	application of desensitizing medicament	Two of (D1206, D1208, D9910) per 12 months, per member.	0%	50%	No
D9930	treatment of complications (post-surgical)	Once per year per member. Not to be used for routine post-operative care or dry socket treatment	0%	50%	Yes
D9950	occlusion analysis-mounted case	One of (D9950, D9952) per 60 months, per member.	0%	50%	Yes
D9951	occlusal adjustment - limited	Once per 12 months, per member.	0%	50%	Yes
D9952	occlusal adjustment - complete	One of (D9950, D9952) per 60 months, per member.	0%	50%	Yes
D9995	teledentistry – synchronous; real-time encounter	One of (D9995 or D9996) per member, per date of service. Cannot be billed as standalone code. D9995 or D9996 must be billed with exam code.	0%	50%	Yes
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0%	50%	Yes
D9999	unspecified adjunctive procedure, by report		0%	50%	Yes

DEFINITIONS

Allowable Amount:	The maximum amount the plan will consider for payment of a covered dental service, as determined by the plan's fee schedule, network status of the treating dentist, or applicable reimbursement methodology.
Appeal:	An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received.
Billed Amount:	The amount charged by the Treating Dentist for a dental procedure.
Balance Billing:	When a provider bills a patient more than the plan's allowed cost-sharing amount.
Calendar Year Benefit Maximum:	The total dollar amount a plan will pay for covered comprehensive dental services provided to a member during a calendar year (January 1 through December 31). Once this limit is reached, the member is responsible for all additional costs incurred during the same calendar year.
Complaint:	The formal name for making a complaint is filing a grievance. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.
Cost-Share/Cost-Sharing:	Amounts that a member has to pay when services are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed copayment amount that a plan requires when a specific service is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.
Covered Services:	The dental services that are covered by our plan.
Deductible:	The amount you must pay for health care or prescriptions before our plan pays.
Dental Emergency:	When you have a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result in either: placing your dental health in serious jeopardy or serious impairment to dental functions.
Grievance:	A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.
Incomplete Services:	Dental procedures that were started but not finished or delivered to the member. An incomplete service has not reached the stage at which the intended clinical outcome or final restoration is achieved.

In-Network / Network:	Provider is the general term for doctors, other health care professionals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. Network providers have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.
Member:	Person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).
Member Services:	A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeal.
Multi-Stage Treatment:	A dental procedure that takes more than one visit to finish. Each appointment completes an important step in the same treatment, such as creating a crown or denture.
Optional Services:	A dental service that is not considered medically or dentally necessary to achieve the intended therapeutic outcome and therefore exceeds or falls outside the scope of covered benefits under the plan.
Out-of-Network:	A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.
Organization Determination:	A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.
Patient:	The person receiving dental services.
Plan:	SCAN Health Plan
Prior Authorization:	Approval in advance to get services. Covered services that need prior authorization are marked in the Schedule of Dental Benefits.
Procedure Code:	The Current Dental Terminology (CDT) code assigned by the American Dental Association (ADA) to identify a specific dental service or procedure.
Treating Dentist:	The dentist providing dental services and care.
Us:	SCAN Health Plan
We:	SCAN Health Plan
You, Your, Yourself:	The person receiving dental services.

CLAIM REIMBURSEMENT

Network providers should submit claims on your behalf. If you are requesting reimbursement for care obtained from a network provider, contact your dental office or DentaQuest's Customer Service to confirm the charges and review reimbursement options.

Please submit request for reimbursement, along with all required documentation, within 90 days from treatment to:

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

Required Documentation includes:

- Claim Reimbursement Form
- Itemized Statement
- Proof of Payment

Dental Reimbursement Form

To request reimbursement, submit this form along with your itemized receipt and proof of payment to:

DentaQuest Claims
 PO Box 2906
 Milwaukee, WI 53201-2906
 Fax: 1-262-834-3589

1. Member Details		
First Name:	Middle Initial:	Last Name:
Date of Birth (mm/dd/yyyy):		
Name of Insurer:		
Member ID number (as shown on your member ID card):		
Policy number (as shown on your member ID card):		
2. Contact Information		
Street Address:	Apt:	
City:	State:	Zip code:
Telephone Number:		
Email (optional):		
3. Provider Information		
Name of Provider:	Provider NPI/TIN (optional):	
Name of Provider Office:		
Address:	Suite:	
City:	State:	Zip code:
Telephone Number:	Fax:	



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