

# 2026 DENTAL GUIDE

## Preventive

### Medicare Advantage Plan

Arizona

California

Nevada

New Mexico

Texas

**DentaQuest**<sup>TM</sup>  
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. 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 MyChoice (HMO)	Maricopa Pima Pinal
CA	SCAN Compass (HMO)	Alameda
CA	SCAN Essential Savings (HMO)	Los Angeles
CA	SCAN MyChoice (HMO)	Alameda / Fresno / Kings / Los Angeles / Madera / Orange / Placer / Riverside / Sacramento / San Bernardino / San Diego / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Yolo
CA	Sutter Senior Advantage (HMO)	Placer / Sacramento / Stanislaus / San Joaquin / Yolo
NA	SCAN MyChoice (HMO)	Clark
NM	SCAN MyChoice (HMO)	Bernalillo Sandoval
TX	SCAN MyChoice (HMO)	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 <b>www.dentaquest.com</b> SCAN Health Plan <b>www.scanhealthplan.com</b>
CALL	<p><b>DentaQuest ..... 1-877-227-1625</b></p> <p><b>SCAN Health Plan</b></p> <p>California ..... <b>1-800-559-3500</b></p> <p>Arizona..... <b>1-855-650-7226</b></p> <p>New Mexico ..... <b>1-855-826-7226</b></p> <p>Nevada ..... <b>1-855-827-7226</b></p> <p>Texas ..... <b>1-855-844-7226</b></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 4 of this document and we will send you a new card.

## Dental Provider Selection

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

Network providers are the doctors and other health care professionals that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. You must use network providers to get your dental care and services. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in network) and cases in which SCAN Health Plan authorizes use of out-of-network providers.

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><b>DentaQuest</b></p> <ol style="list-style-type: none"><li>1. Visit <a href="http://www.DentaQuest.com">www.DentaQuest.com</a>.</li><li>2. Input your location.</li><li>3. Within the drop-down menu:<ul style="list-style-type: none"><li>• Update Insurance Type to “Medicare”</li><li>• Choose “SCAN Health Plan”</li></ul></li><li>4. Click on “Find A Dentist”.</li></ol> <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><b>DentaQuest</b> <b>1-877-227-1625</b></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>

Method	Contact Information
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>

**Prior Authorization**

Payment to providers is subject to applicable 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.

## 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 Member Service to confirm the charges and review reimbursement options.

If you are requesting reimbursement for emergency services, please submit the request within 90 days of treatment to:

DentaQuest  
PO Box 2906  
Milwaukee, WI 53201-2906

# 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><b>SCAN Health Plan</b></p> <p>California ..... <b>1-800-559-3500</b></p> <p>Arizona..... <b>1-855-650-7226</b></p> <p>New Mexico ..... <b>1-855-826-7226</b></p> <p>Nevada ..... <b>1-855-827-7226</b></p> <p>Texas ..... <b>1-855-844-7226</b></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>
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FAX	<p>1-562-989-0958</p>
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
AZ	SCAN MyChoice (HMO)	Maricopa Pima Pinal
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CA	SCAN MyChoice (HMO)	Alameda / Fresno / Kings / Los Angeles / Madera / Orange / Placer / Riverside / Sacramento / San Bernardino / San Diego / San Francisco / San Joaquin / San Mateo / Santa Clara / Stanislaus / Tulare / Yolo
CA	Sutter Senior Advantage (HMO)	Placer / Sacramento / Stanislaus / San Joaquin / Yolo
NA	SCAN MyChoice (HMO)	Clark
NM	SCAN MyChoice (HMO)	Bernalillo Sandoval
TX	SCAN MyChoice (HMO)	Bexar Fort Bend Harris Montgomery

# BENEFIT CONDITIONS, LIMITATIONS, AND EXCLUSIONS

## Conditions

- 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.
- Out-of-pocket expenses related to the receipt of supplemental dental services do not count toward your maximum out-of-pocket amount.
- 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.

## Exclusions

Benefits are not considered for:

- Any dental procedure which is not listed within the 'Schedule of Dental Benefits'.
- Services performed by an out-of-network dental provider.
- Services which are cosmetic in nature and/or completed for cosmetic purposes.
- 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) every 12 months, per member.	0%	Not Covered	No
D0140	limited oral evaluation-problem focused	Two per 12 months, per member. Not allowed with routine services	0%	Not Covered	No
D0150	comprehensive oral evaluation - new or established patient	Two of (D0120, D0150, D0180) per 12 months, per member. One of (D0150, D0180) per 12 months, per provider, per location, per member.	0%	Not Covered	No
D0160	detailed and extensive oral eval-problem focused, by report	Two (D0120, D0160) every 12 months, per member.	0%	Not Covered	No
D0180	comprehensive periodontal evaluation - new or established patient	Two of (D0120, D0150, D0180) per 12 months, per member. One of (D0150, D0180) per 12 months, per location, per member.	0%	Not Covered	No
D0270	bitewing - single radiographic image	Two every 12 months, per member.	0%	Not Covered	No
D0272	bitewings - two radiographic images		0%	Not Covered	No
D0701	panoramic radiographic image-image capture only	One every 12 months, per member.	0%	Not Covered	No
D0702	2-D cephalometric radiographic image-capture only		0%	Not Covered	No
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally-image capture only		0%	Not Covered	No
D0705	extra-oral posterior dental radiographic image-image capture only		0%	Not Covered	No
D0706	intraoral-occlusal radiographic image-image capture only		0%	Not Covered	No

CDT Code	CDT Description	Limitations	Member Cost-Sharing		Prior Authorization Required
			In-Network	Out-of-Network*	
D0707	intraoral-periapical radiographic image-image capture only	One every 12 months, per member.	0%	Not Covered	No
D0708	intraoral-bitewing radiographic image-image capture only		0%	Not Covered	No
D0709	intraoral-comprehensive series of radiographic images-image only		0%	Not Covered	No
D1110	prophylaxis - adult	Two of (D1110, D4346) every 12 months, per member.	0%	Not Covered	No
D1206	topical application of fluoride varnish	Two of (D1206, D1208, D9910) per 12 months, per member.	0%	Not Covered	No
D1208	topical application of fluoride - excluding varnish		0%	Not Covered	No
D4341	periodontal scaling and root planing - four or more teeth per quadrant	One of (D4341 or D4342), per quadrant, per 12 months, per member.	0%	Not Covered	No
D4342	periodontal scaling and root planing - one to three teeth per quadrant		0%	Not Covered	No
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Two of (D1110, D4346) every 12 months, per member.	0%	Not Covered	No
D4910	periodontal maintenance procedures	One of D4910 every 12 months, per member.	0%	Not Covered	No

# DEFINITIONS

<b>Allowable Amount:</b>	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.
<b>Appeal:</b>	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.
<b>Billed Amount:</b>	The amount charged by the Treating Dentist for a dental procedure.
<b>Balance Billing:</b>	When a provider bills a patient more than the plan's allowed cost-sharing amount.
<b>Calendar Year Benefit Maximum:</b>	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.
<b>Complaint:</b>	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.
<b>Cost-Share/Cost-Sharing:</b>	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.
<b>Covered Services:</b>	The dental services that are covered by our plan.
<b>Deductible:</b>	The amount you must pay for health care or prescriptions before our plan pays.
<b>Dental Emergency:</b>	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.
<b>Grievance:</b>	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.
<b>Incomplete Services:</b>	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.

<b>In-Network / Network:</b>	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.
<b>Member:</b>	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).
<b>Member Services:</b>	A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeal.
<b>Multi-Stage Treatment:</b>	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.
<b>Optional Services:</b>	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.
<b>Out-of-Network:</b>	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.
<b>Organization Determination:</b>	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.
<b>Patient:</b>	The person receiving dental services.
<b>Plan:</b>	SCAN Health Plan
<b>Prior Authorization:</b>	Approval in advance to get services. Covered services that need prior authorization are marked in the Schedule of Dental Benefits.
<b>Procedure Code:</b>	The Current Dental Terminology (CDT) code assigned by the American Dental Association (ADA) to identify a specific dental service or procedure.
<b>Treating Dentist:</b>	The dentist providing dental services and care.
<b>Us:</b>	SCAN Health Plan
<b>We:</b>	SCAN Health Plan
<b>You, Your, Yourself:</b>	The person receiving dental services.





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