



CALIFORNIA

Summary of Benefits & Copayments (HMO)

Dental 140

PREVENTIVE SERVICES

| Preventive Services | Member Pays |
|---|-------------|
| — Office visit | \$5.00 |
| 00210 X-rays, full mouth | \$5.00 |
| 00220 X-rays, single film | No Charge |
| 00230 X-rays, each additional film | No Charge |
| 01110 Teeth cleaning - adult or child | \$15.00 |
| 01201 Topical fluoride (including cleaning) - child | \$13.00 |
| 01351 Sealant - per tooth (under age 18)..... | \$10.00 |
| 00470 Diagnostic casts (non-orthodontic)..... | \$20.00 |
| 09110 Emergency treatment (palliative)..... | \$10.00 |
| 09440 Office visit (after hours) | \$20.00 |

ROUTINE SERVICES

| Restorative Dentistry | |
|--|----------|
| — Amalgam restorations (cavities involving primary and permanent teeth) | |
| 02110 One tooth surface - primary..... | \$14.00 |
| 02140 One tooth surface - permanent | \$19.00 |
| 02120 Two tooth surfaces - primary..... | \$18.00 |
| 02150 Two tooth surfaces - permanent | \$23.00 |
| 02130 Three tooth surfaces - primary..... | \$22.00 |
| 02160 Three tooth surfaces - permanent | \$27.00 |
| 02951 Pin retention, in addition to final restoration - per tooth | \$20.00 |
| 02940 Sedative filling..... | \$10.00 |
| Oral Surgery | |
| — Extractions | |
| 07110 Single tooth - uncomplicated (non-orthodontic) . | \$15.00 |
| 07120 Each additional tooth - same visit | \$15.00 |
| 07220 Removal of impacted tooth - soft tissue | \$60.00 |
| 07230 Removal of impacted tooth - partially bony | \$70.00 |
| 07240 Removal of impacted tooth - completely bony | \$90.00 |
| 07210 Surgical removal of an erupted tooth..... | \$35.00 |
| 07285 Biopsy of oral tissue (hard) | \$30.00 |
| 07286 Biopsy of oral tissue (soft)..... | \$20.00 |
| 07310 Alveoplasty, in conjunction with extractions - per quadrant | \$60.00 |
| 07320 Alveoplasty, not in conjunction with extractions - per quadrant..... | \$80.00 |
| 09220 General anesthesia - first 30 minutes..... | \$125.00 |
| 09221 General anesthesia - each additional 15 minutes. | \$60.00 |
| 09240 Intravenous sedation | \$140.00 |
| Endodontics | |
| 03110 Pulp capping (direct)..... | \$10.00 |
| 03120 Pulp capping (indirect)..... | \$12.00 |
| 03220 Therapeutic pulpotomy..... | \$15.00 |
| — Root canals (per tooth) | |
| 03310 Anterior (excluding final restoration)..... | \$110.00 |
| 03320 Bicuspid (excluding final restoration)..... | \$130.00 |
| 03330 Molar (excluding final restoration) | \$200.00 |

ROUTINE SERVICES (CONT'D)

| Periodontics | Member Pays |
|--|-------------|
| 04220 Gingival curettage, root planing - per quadrant | \$50.00 |
| 04210 Gingivectomy - per quadrant..... | \$120.00 |
| 04250 Mucogingival surgery - per quadrant | \$310.00 |
| 04211 Gingivectomy - per tooth | \$35.00 |
| 04910 Perio recall including prophy | \$25.00 |
| 09952 Occlusion adjustment (complete)..... | No Charge |

MAJOR SERVICES

| Crowns | |
|--|----------|
| 02930 Stainless steel crown - primary tooth | \$25.00 |
| 02932 Resin crown (not for molars) | \$25.00 |
| 02791 Full metal crown | \$250.00 |
| 02810 3/4 metal crown* | \$250.00 |
| 02740 Porcelain crown (not for molars) | \$250.00 |
| 02751 Porcelain with metal crown (not for molars) *..... | \$250.00 |
| 02751 Porcelain with metal crown (for molars) * | \$250.00 |
| 02952 Cast post & core, in addition to crown* | \$90.00 |
| 02954 Prefabricated post & core, in addition to crown..... | \$50.00 |
| Pontics | |
| 06211 Pontic, cast metal (base) | \$250.00 |
| 06242 Pontic, porcelain with metal* | \$250.00 |
| 02910 Inlay recementation | \$10.00 |
| 02920 Crown recementation | \$10.00 |
| 06930 Bridge recementation..... | \$10.00 |

Prosthetics

| Dentures and partials | |
|---|-----------|
| 05110 - 05120 Complete denture, upper or lower | \$300.00 |
| 05211 - 05212 Partial denture, upper or lower with resin base.. | \$300.00 |
| 05410 - 05422 Adjustment | No Charge |
| 05510 - 05640 Repair | \$30.00 |
| 05650 - 05660 Add tooth or clasp..... | \$30.00 |
| 05730 - 05741 Reline (chairside)..... | \$40.00 |
| 05750 - 05761 Reline (lab processed) | \$65.00 |
| 01510 - 01515 Fixed space maintainer (band type)..... | \$65.00 |
| 01520 - 01525 Removable acrylic space maintainer..... | \$65.00 |

Dentist may charge \$20.00 for broken appointments if not notified at least 24 hours in advance.

**Plus actual lab cost of precious metal.*

ORTHODONTICS

The orthodontic benefit covers: consultation, all necessary appliances, banding, and monthly office visits for 24 months.

| | |
|---|------------|
| Class I (teeth straightening) | \$1,895.00 |
| Class II (correction of overbite) | \$1,895.00 |
| Class III (correction of underbite) | \$1,895.00 |

Specific copayment levels have also been set for start-up and retention services.

Orthodontic treatment must be provided by a PacifiCare Dental Panel Orthodontist.

A referral must be submitted by your assigned dental provider to PacifiCare Dental.

A Summary of Benefits and Copayments

DENTAL 140

How do I Enroll?

1. Please complete a *Member Enrollment* application. Instructions are provided on the back of the application.
2. Be sure to select a dental office from the list we have provided. Write the number of the provider group, dentist name, and city that you have selected on your *Member Enrollment* application. Also circle that office on the list and keep it to remind yourself which office you selected.
3. Under the Selected Coverage section of the *Member Enrollment* application mark the box labeled - PacifiCare SignatureValue.
4. If you do not want dental coverage because you are currently covered under someone else's dental plan, please complete the *Refusal of Employee and/or Dependent Coverage* form instead.
5. Return the completed *Member Enrollment* application or *Refusal of Employee and/or Dependent Coverage* form to your benefits administrator. Keep this brochure for reference until you receive your PacifiCare Dental ID card, *Evidence of Coverage and Disclosure Form*, and *Principal Benefits and Coverages* policy booklets.

If you need to visit your dentist before you receive your ID card and booklets, call the phone number given for the dental office you circled. Tell them you have just enrolled in PacifiCare Dental, and that your eligibility can be confirmed by calling **PacifiCare Dental's Eligibility Line at 1-800-622-0161**.

Many benefit copayments, as well as major exclusions and limitations, are listed in this brochure. However, more detailed information is given in your *Evidence of Coverage and Disclosure Form* booklet, which you will receive in a few weeks. You should refer to this brochure only until your *Evidence of Coverage and Disclosure Form* booklet and *Principal Benefits and Coverages* policy booklets arrive.

If, upon your effective date, you are under treatment for an acute dental condition through a non-contracted dental provider, PacifiCare Dental will honor your claims, subject to the limitations and exclusions of your plan. Please contact Member Services for directions on continuing your care.

If you have any questions concerning your benefits, please call **PacifiCare Dental's Member Service Department at 1-800-22-TEETH (1-800-228-3384)**.

Your Whole Family is Eligible.

California residents and their eligible dependents are qualified for plan benefits. Eligible dependents include your spouse and unmarried dependent children up to age 19. (Age limitations may vary. Consult your benefits administrator for specific age requirements.)

For full-time students ages 19 through 24, verification must be provided by the school attended by the 20th of the month preceding coverage. A full-time student is defined as taking at least 12 semester units.

All copayments listed in the *Summary of Benefits* are paid by the member directly to their assigned dental office.

Emergency Care is Also Covered.

If an emergency occurs and you are required to receive dental care at a place other than your assigned dental office, PacifiCare Dental will reimburse you for covered emergency treatment only, less any applicable copayments.

Limitations

- Denture and partial replacement: only when dentures cannot be made serviceable
- Cleanings: once every six months
- Full mouth x-rays: once every two years
- Pedodontic referrals (*through age 18 as necessary*): referral covered to 51% of specialist's fees
- Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impaction)

Exclusions

- Dispensing of drugs (*prescription or over-the-counter*)
- Teeth extracted for orthodontic purposes
- Treatment of Temporomandibular Joint Syndrome (TMJ)
- Oral surgery requiring the setting of fractures or dislocations
- Treatment of malignancies, cysts, or neoplasms
- Cosmetic dentistry
- Lost or stolen dentures or orthodontic appliances

This summary of benefits and copayments constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. You may ask for a copy of that contract from your employer group.

PacifiCare®
Dental

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