



BEST HEALTH PLANS



Advantage Dental HMO Plans

For California | Group Sizes 2 or more

Offered and administered by Dental Benefit Providers of California, Inc.
Marketed and Distributed by BEST Health Plans, LLC.

Bringing Value with Affordable Dental Care

Dental plans are the second benefit most asked for by employees. With BEST Health Plans Advantage Dental HMO plans, employer groups as small as 2 employees enrolling can now offer these valuable benefits to their organization.

Voluntary Dental Plans

All of the Advantage Dental HMO plans are offered on a voluntary basis and provide a low-cost option for employers. Voluntary rates are available for groups who demonstrate less than 50% participation, have less than 50% contribution or who do not have proof of prior coverage. A minimum of 2 employees enrolling is required.

Dual Option

BEST Health Plans sell a variety of dental plans that can be offered alongside these Dental HMO plans. Please contact your BEST Health Plans Sales Representative for plan information.



Advantage Dental HMO Plans



Advantage Dental HMO



Offer your clients the advantage of affordability with a dental HMO plan. Individuals and families enrolled on the Advantage plans receive most diagnostic and preventive care at no charge. Our plans are guaranteed to provide copayments between 25% and 60% discount of what is normally charged for dental care.

With Advantage Dental HMO there are

- ✔ No office visit fees
- ✔ No waiting periods
- ✔ No claim forms required
- ✔ No deductibles
- ✔ Posterior composites and oral cancer screenings (brush biopsy) available at a fixed copay
- ✔ Adult and child orthodontia services covered at a fixed copay

The Dental Benefit Providers of California (“DBP-CA”) Network

Members on the Advantage Dental HMO Plans can select any general dentist from the DBP-CA network, and each family member may choose a different general dentist. To ensure access to care, members select a DBP-CA participating general dentist at the time they enroll in the plan. To change dentists, members can call our Member Services Department.

My Dental Health Web Portal

The Advantage Dental HMO Plans provides members an online portal where they can logon for:

- **Dentist Locator** enables members to find general dentists and specialists close to their home or office, including maps and printable driving directions to the dentist’s office. Members can also Nominate a Dentist to join the DBP network.
- **Plan Information** for verifying eligibility for family members, request ID cards and review benefit plan summaries which detail the amount the plan pays for procedures. The treatment cost calculator allows for members to determine their out of pocket costs prior to seeing a dentist. A Frequently Asked Questions provides answers to commonly asked questions about the dental plan, including Member Service and Claims information.
- **The Dental Education** section offers little-known facts about the dental industry, dental articles, brushing and flossing techniques, an A-Z guide of frequently used dental words, and more.



Advantage Dental HMO Plan Overview

Code	Benefit	G301	G192	G191
D9999	Office visit	None Applies	None Applies	None Applies
Diagnostic Services				
D0120	Periodic oral evaluation (every 6 months)	No Charge	No Charge	No Charge
D0150	Comprehensive oral evaluation	No Charge	No Charge	No Charge
D0210	Complete series x-rays	No Charge	No Charge	No Charge
D0270	Bitewings – single film	No Charge	No Charge	No Charge
D0330	Panoramic film	No Charge	No Charge	No Charge
Preventive Services				
D1110	Prophylaxis – adult (every 6 months)	No Charge	No Charge	No Charge
D1120	Prophylaxis – child (every 6 months)	No Charge	No Charge	No Charge
D1201	Topical application of fluoride (including prophylaxis) < age 14 (every 6 months)	No Charge	No Charge	No Charge
D1351	Sealant – per tooth	\$10	No Charge	No Charge
D1510	Space maintainer – fixed - unilateral	\$50	No Charge	No Charge
Restorative & Prosthodontic Services				
D2140	Amalgam – one surface	\$10	\$13	\$20
D2391	Resin-based composite – one surface, posterior	\$12	\$17	\$26
D2630	Inlay – porcelain/ceramic, three surfaces	\$195	\$200	\$200
D2752	Crown – porcelain fused to noble metal	\$250	\$280	\$280
D5110	Complete upper denture	\$275	\$355	\$355
D5211	Upper partial denture	\$100	\$370	\$370
D6240	Pontic – porcelain fused to noble metal	\$250	\$275	\$265
Endodontic Services				
D3320	Root canal therapy – bicuspid	\$125	\$105	\$175
D3330	Root canal therapy – molar	\$180	\$130	\$240
Periodontic Services				
D4260	Osseous surgery	\$275	\$130	\$315
D4341	Periodontal scaling & root planing – per quadrant	\$60	\$30	\$75
D4910	Periodontal maintenance after active therapy	\$50	\$20	\$45
Oral Surgery				
D7230	Removal of impacted tooth – partially bony	\$60	\$50	\$95
D7288	Brush Biopsy (for oral cancer screening)	\$80	\$18	\$60
Orthodontic Services				
D8080	Comprehensive orthodontic treatment of adolescent dentition (24 month case)	\$1,850	\$1,900	\$1,900
D8090	Comprehensive orthodontic treatment of adult dentition (24 month case)	\$2,200	\$2,275	\$2,275
D8660	Pre-orthodontic treatment visit (Orthodontic consult)	\$40	\$40	\$40

Specialty Care

When a member requires treatment by a dental specialist, the member's general dentist will submit a referral to BEST Health Plans for pre-authorization. Listed services provided by a participating dental specialist (Oral Surgeon, Endodontist, Orthodontist, Periodontist, Prosthodontist or Pedodontist) are covered at copay.

The following is a summarized list of exclusions and limitations. For a complete list, please refer to the plan's Schedule of Benefits.

Limitations

1. PROPHYLAXIS - Routine cleaning of teeth, including scaling and polishing procedures to remove coronal plaque, calculus and stains, once every 6 months.
2. FULL MOUTH RADIOGRAPHS (X-rays) once in any 2-year period. Bitewing X-rays are limited to no more than 1 series of 4 films in any 6-month period.
3. FLUORIDE TREATMENTS once per calendar year.
4. PERIODONTAL SCALING AND ROOT PLANING - allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of 4 quadrants per calendar year.
5. PERIODONTAL MAINTENANCE PROCEDURES following active therapy (previous to periodontal treatment) once every 6 months at the Specialist's office when referred by your Assigned Dental Provider Group, or provided at your Assigned Dental Provider Group
6. PROSTHETICS
 - A. REMOVABLE PROSTHETICS
 1. Temporary or Transitional Dentures - Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for an anterior stayplate when this interim appliance either:
 - a. Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
 - b. Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.
 2. Laboratory Upgrades including specialized services for Dentures are not covered. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. Upgrades include, but are not limited to:
 - a. Precious metal for removable appliance framework or a metal base for a full denture;
 - b. Personalization and characterization;
 - c. Specialized materials;
 - d. Specialized services or techniques involving precision attachments or stress breakers.
 3. Dentures, Replacement, Repairs and Relines
 - a. For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered.
 - b. If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits
 - c. Denture adjustments - Adjustments for new dentures are included in the Copayment for the denture for 6 months following delivery. For existing dentures, or new dentures after the initial 6 months, the Member is responsible for the listed Copayment for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a covered benefit.
 - B. FIXED PROSTHETICS:
 1. A fixed bridge is a benefit to replace missing natural teeth, unless based on professionally recognized standards:
 - a. The clinical condition of the teeth that would support the bridge is unfavorable.
 - b. There are inadequate teeth available to support the bridge.
 - c. The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
 - d. The new bridge would replace an existing bridge that is still serviceable.
 - e. A bridge would be used only to realign malaligned teeth.
 2. A fixed bridge is a benefit to replace missing natural teeth, unless:
 - a. The requested service is for a new bridge and a new partial denture in the same arch. In such cases the Covered Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
 - b. A Member under 16 years of age loses a permanent tooth; in which case an anterior stayplate or space maintainer would be the covered benefit to replace the missing tooth. If the bridge is placed, patient or guardian must pay the dentist's billed charges.
 - c. The bridge would be supported in whole or in part by dental implants, or acid-etched resin bridge retainers (a "Maryland" bridge). A bridge would be used only to realign malaligned teeth.
 - d. It is a long spanning bridge (anything beyond 4 abutments and/or pontics).
 - e. The bridge would have an abutment (support) only on 1 side (cantilever bridge).

C. SINGLE CROWNS, INLAYS AND ONLAYS

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling, or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of specialized materials, i.e., precious or semi-precious metals in crowns, is considered a laboratory upgrade, which the dentist may offer the Member for a fee not to exceed the amount charged to the dentist by the dental laboratory for the upgraded materials. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. For example, the Provider offers, and the Member accepts, the alternative of a precious (gold) crown instead of a base metal crown. The Provider may charge no more than the listed Copayment for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal and/or any other specialized material.

1. Porcelain, porcelain-fused-to-metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the Provider's Billed Charges.
 2. Replacement of an inlay, onlay, porcelain or PFM crown is a covered benefit as long as the existing restoration is unserviceable, and can not be made serviceable, as determined by your assigned dentist.
 3. For crowns and fixed bridges, the maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
7. **OCCUSAL EQUILIBRATION** – This means the reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. Adjustment of the bite on a new restoration, crown, bridge, and denture will be provided at no additional charge if performed by the DBP-CA Participating Provider who provided the restoration service. However, the correction of occlusion on natural teeth or existing restorations is not a Covered Service.
8. **DOWEL POSTS AND PINS** - Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate Covered Service if deemed necessary by a DBP-CA Participating Provider to provide adequate retention of a restoration.
9. **SPECIALTY REFERRAL** - dental treatment by a Specialist is limited to:
- Dental plans which include specialty referral benefits
 - Covered dental services performed by an oral surgeon, endodontist and periodontist that are beyond the scope of practice of a general dentist

- Pedodontic referrals apply to all children through age 18 as necessary
- Services by an orthodontist, if the Member's Dental Plan specifically includes DBP-CA's orthodontic benefit.

10. RESTORATIONS AND DENTAL PROSTHETICS

- A. Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not Covered Services. To restore the occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s), and/or denture(s) to establish an altered bite or relationship between the jaws.
- B. Composite restorations on posterior teeth may not be a benefit for all plans. Please refer to your Schedule of Benefits.

11. **I.V. SEDATION OR GENERAL ANESTHESIA** - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).

Exclusions

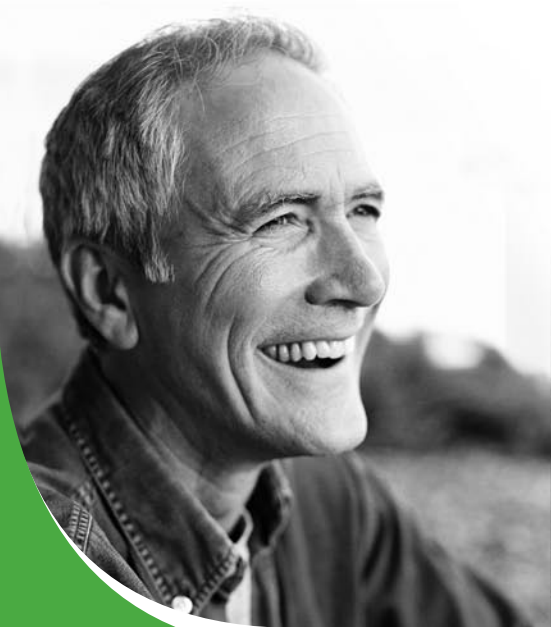
The following procedures and services are excluded and not Covered Services:

1. Specialty referral benefits, unless otherwise indicated in the Schedule of Benefits, are not covered.
2. Services provided by a prosthodontist are not covered.
3. Cosmetic dental care is not covered.
4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Member's Assigned Dental Provider Group, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
5. Treatment of fractured bones and dislocated joints is not covered.
6. Lost or stolen dentures are not covered.
7. Crowns or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances are not covered.
9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.

10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with DBP-CA, whichever is earlier, or started by a Non-Participating Provider without the prior approval of DBP-CA is not covered. This exclusion does not apply to a current Member:
 - who has temporary restorative services
 - whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.
14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue are not covered.
15. Prescription drugs and over-the-counter medicines are not covered.
16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fibrotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in this Combined Evidence of Coverage and Disclosure Form.
19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered.
22. Amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not Covered Services. If performed, the patient must pay the dentist's Billed Charges.

These services include:

 - Realignment of teeth
 - Gnathologic recording
 - Equilibration
 - Occlusal splints and night guards
 - Overlays, implant supported partial dentures and overdentures
 - The replacement of otherwise serviceable existing restorations and dental prosthetics
 - Precision attachments and stressbreakers
24. Dental services that the Plan or Participating Provider determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N2O2 - nitrous oxide) is not covered.



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