Most Common Questions

WHAT IS A "MANAGED CARE" DENTAL PLAN?
A "Managed Care" dental plan contracts directly with licensed dental professionals to deliver quality dental care to its members.

HOW TO USE YOUR PLAN?
General Dental Services: Please select a dental office from the list of contracted Plan providers and indicate the dental office and ID# on the enrollment form. The Plan will assist you in selecting a dentist whenever you request such assistance. Thereafter, to obtain services, you need only contact the selected Plan provider and make an appointment. In the event you are dissatisfied with any Plan provider selected, for any reason, and desire to transfer to another, you may do so by contacting the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

Specialty Services: Should your treatment plan require the services of a specialist you will be referred by your Plan provider. All benefits and copayments apply to specialty services provided the referral has the prior approval of the Plan's Dental Director. If you need assistance with obtaining a specialty referral, please contact the Customer Care Department listed below.

Emergency Services or Urgent Care: Should you need urgent care, or are experiencing a dental emergency, please contact your Plan provider and indicate that you are in need of urgent or emergency care. If you need assistance with obtaining emergency or urgent care from your Plan provider, or are out of the area, you may contact Customer Care at the toll-free number listed on your dental ID card during normal business hours to arrange for out-of-area emergency care.

After Hours Care: If you need services after hours, first contact your assigned Plan provider. Plan providers are required to have 24-hour access to on-call care. If you are unable to contact your Plan provider, this plan provides for reimbursement for any emergency or after hours care out of the area up to $100, less any usual copayments required for any procedures performed on a fee-for-service basis. If you need such care after hours, you must notify the Plan within 48 hours of receiving care from a non-participating provider.

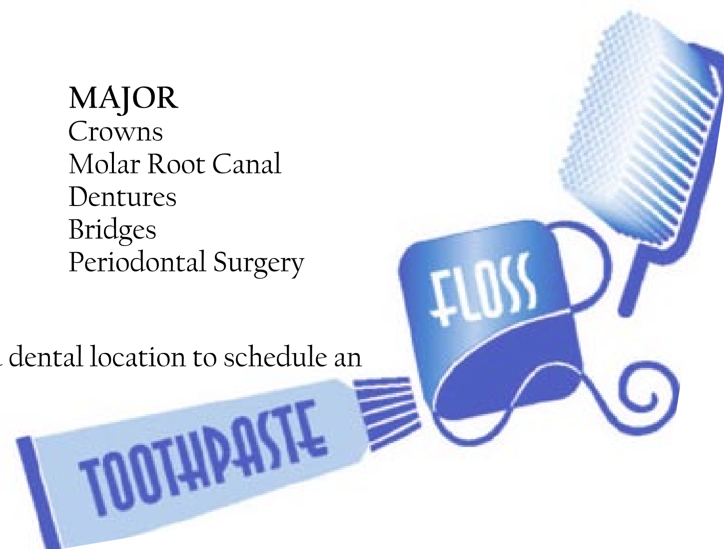
Out-of-Area Care: To receive dental care out of your area, first contact Customer Care at the toll-free number listed on your dental ID card to determine if you can be served by another contracted Plan provider. If you are more than 50 miles from a contracted Plan provider, you may be directed to seek care from a non-Plan provider. If you need services after hours, please refer to the above After Hours Care section.

WHAT ARE THE BENEFITS?

PREVENTIVE	BASIC	MAJOR
Exams	Fillings	Crowns
Cleanings	Simple Extractions	Molar Root Canal
X-rays		Dentures
		Bridges
		Periodontal Surgery

HOW IS CARE RECEIVED?
The member may receive care by simply calling the selected dental location to schedule an appointment. There are no forms or cards required.

WHAT ABOUT MISSED APPOINTMENTS?
If a member fails to cancel an appointment at least 24 hours in advance, a "failed appointment fee" will be charged and no further appointments will be made until the cancellation fee is paid.



DENTAL BENEFIT PROVIDERS OF CA, INC
800-999-3367 - 925-363-6000

Benefit Schedule

HOW DOES YOUR DENTAL PLAN WORK?
Dental Benefit Providers of California, Inc. ("DBP-CA") has created a Plan that offers our members quality dental health services at a significant savings. We have contracted with quality, local dental professionals to provide services to you and your eligible dependents at no cost or for low fixed copayments. The following is an example of the potential savings on a typical case.

	PUD	Usual & Customary Fees
Office Exam & X-rays	No Charge	$45
Cleanings (2) - one every 6 months	No Charge	$90

TAKE ADVANTAGE OF THE BENEFITS
In addition to substantial savings, there are many other advantages as described in this brochure. Under this plan, there are **no claim forms** to complete, **no deductibles** to be met and **no yearly dollar maximum** of coverage.

MEMBERSHIP ELIGIBILITY
This plan is designed for the employee and, if eligible, his/her family. Unless stated otherwise by your group, coverage is extended to the spouse and/or dependent children. Dependent children include: 1. All natural, 2. Adopted, 3. Step-children. An dependent child will be eligible to age 26 (or subject to age limitations established by group or organization). Automatic coverage is provided for mentally and/or physically challenged dependent children.

CHOOSE YOUR DENTIST AND OFFICE
You and your family choose your dentist from a wide network of private dental offices. A list of dental offices is provided to permit each member to choose the most convenient office. The member and dependents may select different dental offices. If so desired, you may transfer to a different Plan office. Simply notify the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

OTHER BENEFITS
• Maximum benefits allowed annually per person are unlimited • No deductibles • No claim forms required
• You know your exact "out-of-pocket" costs, if any • You may select the participating dentist of your choice.

ENROLLMENT PROCEDURE
Simply fill out and return the enclosed enrollment form to your Benefits Administrator at your place of employment or return it to your Trust Fund Office.

OTHER CHARGES
The member pays the copayments listed on the Benefit Copayment Schedule for each dental procedure completed by the dentist. These fees must be paid directly to the participating dental office where the dental treatment is received. Payments are due on the day of service unless prior arrangements have been made with your dental provider.

TERMINATION OF BENEFITS
1. On expiration date of dental coverage.
2 When a dependent member attains the age of 26 or subject to age limitations established by group or organization.
3. Permitting or committing fraud. In the event of termination, the Plan provider shall complete any procedures listed on the Benefit Copayment Schedule commenced prior to the termination date, and the member is required to pay all copayments in accordance with the Benefit Copayment Schedule.
4. Members who violate the Plan's rules may have their benefits suspended or be transferred to an indemnity plan.

ORTHODONTICS
Orthodontic benefits are available to most groups. Coverage varies by area and policy purchased. A seperate Orthodontic Benefit Schedule, if not included, is available from the Plan office. Coverage to orthodontics applies to Phase II treatment only.

NOBLE MATERIALS (GOLD)
If noble materials, not normally prescribed, are requested for fillings, crowns, bridges, or prosthetic devises, there will be an additional charge based on the amount of metal used.

BASIC METHOD OF REIMBURSEMENT
The Plan contracts with general and specialized dentists to provide quality dental services for eligible group members. The Plan compensates its providers using direct reimbursement, discounted fee-for-service, fee-for-service or capitation. The Plan does not use provider incentives or bonus plans to influence specific dental care decisions.

SECOND OPINION
If the member has a treatment question or concern that cannot be addressed by the member's current Plan provider and/or the Plan's Dental Director, the member may request a second opinion from another Plan dentist. There is no cost for this second opinion except for applicable copayments, if any. The second opinion will be performed by a contracted Plan general dentist or specialist. A second opinion must be arranged through the Customer Care Department by calling 1-800-999-3367.

ACUTE CARE
The Plan is responsible for immediately providing emergency dental services to our members upon enrollment in our dental plan. Emergency services are subject to the limitations and exclusions found in your evidence of coverage.

BINDING ARBITRATION
In the event you are unable to utilize the "binding arbitration" provision contained in the contract because you believe it will cause you "extreme financial hardship," you may request financial assistance from the Plan. Eligible enrollees may request a copy of the Plan's written policy which includes information on how enrollees may request financial assistance in order to exercise all of their rights under this policy.

CONTINUITY OF CARE
You may have a qualified right to continue care with a previous provider for a designated period of time in some situations. The Plan is in compliance with all state laws involving Continuity of Care Rights. A copy of the Plan's Continuity of Care policy is available upon request from Customer Care.

GRIEVANCE PROCEDURE
Any complaints may be referred to the Plan's Customer Care Department by calling **1-800-999-3367**. Complaint forms and a copy of the grievance procedure are available from the Plan.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-3367** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

DBP-CA does not discriminate or tolerate discrimination of any kind against an enrollee who has filed a complaint with the Plan of any kind (i.e. against a provider or the Plan itself, or any other complaint). No Plan contract shall be cancelled because an enrollee filed a complaint with the Plan.

PRINCIPAL LIMITATIONS
Set forth below are the limitations that are applicable to this Plan:

1. Prophylaxis is limited to one treatment each six-month period (including periodontal maintenance following active therapy).
2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement regardless of payor. Adjustments to crowns, bridges, and dentures are included in the coverage for the appliance for the first 6 months after initial placement.
3. Partial dentures (including interim partial dentures, resin-based partial dentures, and metal-framework partial dentures) are not to be replaced within any five-year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; an interim partial denture (5820 or 5821) may be replaced with a covered partial denture (5211, 5212, 5213 or 5214) no more than one time in a five-year period from the placement of the interim partial denture (also known as "stayplate").
4. Denture relines are limited to one per denture (including immediate dentures) during any 12 consecutive months.
5. Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
6. The plan allows up to five units of crown or bridgework per arch within a 5-year period. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit within any five-year period.
7. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.
8. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
9. Bitewing x-rays are limited to not more than one series in any six-month period.
10. Full mouth x-rays and panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays.
11. Sealant benefits include the application of sealants to permanent first and second molars and bicuspids with no decay, with no restorations and with the occlusal surface intact up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
12. Single unit cast metal and/or ceramic restorations and crowns are covered only when the member is 17 years of age or older, and the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays. An allowance is made for pre-fabricated crown for children 16 and under.
13. Referral to a dental specialist (if covered) is limited to only those covered procedures that cannot be performed by a contracted general dentist, as determined by the Plan's Dental Director.
14. Third-molar ("wisdom teeth") extraction is limited to only those instances where the teeth cannot be treated in a more conservative manner.
15. Use of cosmetic materials is limited to anterior and posterior composite restorations (including composite restorations on the facial surfaces of premolar teeth), and porcelain-fused-to-metal cast crown restorations on posterior teeth due to decay or fracture. All other cosmetic or esthetic care is excluded from coverage.
16. The Plan benefits cast restoration using predominantly base metal. If the member requests noble or high noble metal be used (e.g., gold, semi-precious metals, etc.), the member may be charged a surcharge based on the additional laboratory charges for such metals.
17. OPTIONAL DENTAL TREATMENT: Listed copayments apply for services ONLY when prescribed by a contracted dentist as a necessary, adequate and appropriate procedure for your dental condition. In some cases there may be more than one appropriate procedure or option to address a dental condition. Optional Dental Treatment is defined as any procedure that is a dental laboratory upgrade of a standard covered service (members may be charged a surcharge based on the additional laboratory costs); OR a more extensive covered service that is an alternative to an adequate, but more conservative, covered dental service. If a member selects a more extensive form of treatment than is recommended by the contracted dentist or that is alternative to an adequate, but more conservative covered dental service, the member may be charged the difference between the contracted dental office's usual fee for the more extensive form of treatment, and the usual fee for the covered treatment, plus the copayment for the covered benefit as listed in the benefit schedule.

PRINCIPAL EXCLUSIONS
The following procedures and services are not included in the Plan:

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs.
2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable, or any other third-party is liable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
3. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all-ceramic cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.
4. Dental services and any related fees performed in a treatment facility other than the contracted provider's office (i.e. hospital, ambulatory care facility, outpatient clinic, surgical center, etc.).
5. Treatment of fractures and/or dislocations of the jaws.
6. Loss or theft of fixed and/or removable prosthetics (crowns, bridges, full or partial dentures) regardless of payor.
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with the Plan (e.g.: teeth prepared for crowns, root canals in progress, fixed or removable prosthetics). Crowns, bridges or dentures started in one office (while under PUD coverage) are considered "in progress" until delivered. Additional benefits will not be provided for such treatment in progress.
8. The Schedule of Benefits of procedures is the definitive statement of coverage, and supersedes all other materials. Any service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.
9. Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and supernumerary teeth.
10. Treatment/removal of malignancies, cysts, tumors or neoplasms.
11. Dispensing of drugs not associated with a course of dental care, such as medicinal irrigation, locally administered antibiotics and prescription drugs.
12. Crowns, bridges and/or dentures placed as a definitive restoration of tooth structure lost as a result of accidental injury. Accidental injury is defined as damage to the hard or soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier, other than a dental plan. (NOTE: "Definitive" refers to a "final" or "permanent" appliance or treatment.)
13. Cases which in the professional opinion of the Plan's attending dentist or Dental Director it is determined that a satisfactory result cannot be obtained or where the prognosis is poor or guarded (i.e. without a minimum service expectancy of 3 years).
14. Dental services received from any dental office other than a Plan's dental office, unless expressly authorized in writing by the Plan or as cited under "Out of Area Emergency Treatment."
15. Removal of asymptomatic teeth, nonpathological teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with or without ligation.
16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
17. Crown lengthening procedures.
18. Replacement of long-standing missing tooth/teeth in an otherwise stable dentition. (Example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion).
19. Dental services and treatments for restoring tooth structure loss from abnormal or excessive wear or attrition, abrasion, abfraction, bruxism, and/or erosion, except when due to normal masticatory function; changing or restoring vertical dimension, or occlusion, and full mouth reconstruction, diagnosis and/or treatment of the temporomandibular joint (TMJ).
20. Dental services that cannot be performed in the Plan's general dental office because of physical, medical or behavioral limitations of eligible enrollees over the age of seven years.
21. Pathology reports are excluded from coverage.