



## 2018 Dental Benefit Plan Designs

Date: **Corrected April 13, 2017**

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.

|   | Children's Dental Plan |                |                      |
|---|------------------------|----------------|----------------------|
|   | Coinsurance Plan       |                | Copay Plan           |
|   | Pediatric Dental EHB   |                | Pediatric Dental EHB |
|   | Up to Age 19           |                | Up to Age 19         |
| <b>Actuarial Value</b>  | 86.8%                  | 86.8%          | 83.2%                |
|   | In-Network             | Out-of-Network | In-Network           |
| <b>Individual Deductible</b>  | \$65                   | \$65           | None                 |
| <b>Family Deductible (Two or more children)</b>   | \$130                  | \$130          | Not Applicable       |
| <b>Individual Out of Pocket Maximum</b>   | \$350                  | None           | \$350                |
| <b>Family Out of Pocket Maximum (Two or More Children)</b>  | \$700                  | None           | \$700                |
| <b>Office Copay</b>   | \$0                    | \$0            | \$0                  |
| <b>Waiting Period</b><br><small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small> | None                   | None           | None                 |
| <b>Annual Benefit Limit</b><br><small>(the maximum amount the dental plan will pay in the benefit year)</small>   | None                   | None           | None                 |

| Procedure Category                 | Service Type                          | Member Cost Share         | Member Cost Share         | Member Cost Share              |
|------------------------------------|---------------------------------------|---------------------------|---------------------------|--------------------------------|
| <b>Diagnostic &amp; Preventive</b> | Oral Exam                             | No charge                 | 10%                       | No charge                      |
|                                    | Preventive - Cleaning                 | No charge                 | 10%                       | No charge                      |
|                                    | Preventive - X-ray                    | No charge                 | 10%                       | No charge                      |
|                                    | Sealants per Tooth                    | No charge                 | 10%                       | No charge                      |
|                                    | Topical Fluoride Application          | No charge                 | 10%                       | No charge                      |
|                                    | Space Maintainers - Fixed             | No charge                 | 10%                       | No charge                      |
| <b>Basic Services</b>              | Restorative Procedures                | 20%<br>Deductible Applies | 30%<br>Deductible Applies | See 2018 Dental Copay Schedule |
|                                    | Periodontal Maintenance Services      |                           |                           |                                |
| <b>Major Services</b>              | Periodontics (other than maintenance) | 50%<br>Deductible Applies | 50%<br>Deductible Applies | See 2018 Dental Copay Schedule |
|                                    | Endodontics                           |                           |                           |                                |
|                                    | Crowns and Casts                      |                           |                           |                                |
|                                    | Prosthodontics                        |                           |                           |                                |
|                                    | Oral Surgery                          |                           |                           |                                |
| <b>Orthodontia</b>                 | Medically Necessary Orthodontia       | 50%<br>Deductible Applies | 50%<br>Deductible Applies | \$350                          |



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|   |                                       | Family Dental Plan           |                              |  |  |
|---|---------------------------------------|------------------------------|------------------------------|--|--|
|   |                                       | Coinsurance Plan             |                              |  |  |
|   |                                       | Pediatric Dental EHB         |                              | Adult Dental   |  |
|   |                                       | Up to Age 19                 |                              | Age 19 and Older   |  |
| <b>Actuarial Value</b>  |                                       | 86.8%                        | 86.8%                        | Not Calculated   | Not Calculated   |
|   |                                       | In-Network                   | Out-of-Network               | In-Network   | Out-of-Network   |
| <b>Individual Deductible</b>  |                                       | \$65                         | \$65                         | \$50   | \$50   |
| <b>Family Deductible (Two or more children)</b>   |                                       | \$130                        | \$130                        | Not Applicable   | Not Applicable   |
| <b>Individual Out of Pocket Maximum</b>   |                                       | \$350                        | None                         | Not Applicable   | Not Applicable   |
| <b>Family Out of Pocket Maximum (Two or More Children)</b>  |                                       | \$700                        | None                         | Not Applicable   | Not Applicable   |
| <b>Office Copay</b>   |                                       | \$0                          | \$0                          | \$0  | \$0  |
| <b>Waiting Period</b><br><small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small> |                                       | None                         | None                         | 6 months for Major Services, Waived with Proof of Prior Coverage | 6 months for Major Services, Waived with Proof of Prior Coverage |
| <b>Annual Benefit Limit</b><br><small>(the maximum amount the dental plan will pay in the benefit year)</small>   |                                       | None                         | None                         | \$1,500  |  |
| Procedure Category  | Service Type                          | Member Cost Share            | Member Cost Share            | Member Cost Share  | Member Cost Share  |
| <b>Diagnostic &amp; Preventive</b>  | Oral Exam                             | No charge                    | 10%                          | No charge  | 10%  |
|   | Preventive - Cleaning                 | No charge                    | 10%                          | No charge  | 10%  |
|   | Preventive - X-ray                    | No charge                    | 10%                          | No charge  | 10%  |
|   | Sealants per Tooth                    | No charge                    | 10%                          | Not Covered<br>No Charge   | Not Covered<br>10%   |
|   | Topical Fluoride Application          | No charge                    | 10%                          | Not Covered<br>No Charge   | Not Covered<br>10%   |
|   | Space Maintainers - Fixed             | No charge                    | 10%                          | Not Covered<br>No Charge   | Not Covered<br>10%   |
| <b>Basic Services</b>   | Restorative Procedures                | 20%                          | 30%                          | 20%  | 30%  |
|   | Periodontal Maintenance Services      | Deductible Applies           | Deductible Applies           | Deductible Applies   | Deductible Applies   |
| <b>Major Services</b>   | Periodontics (other than maintenance) | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies                                     | 50%<br>Deductible<br>Applies                                     |
|   | Endodontics                           |                              |                              |  |  |
|   | Crowns and Casts                      |                              |                              |  |  |
|   | Prosthodontics                        |                              |                              |  |  |
|   | Oral Surgery                          |                              |                              |  |  |
| <b>Orthodontia</b>  | Medically Necessary Orthodontia       | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies | Not Covered  | Not Covered  |



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|   |                                       | Family Dental Plan             |                                     |
|---|---------------------------------------|--------------------------------|-------------------------------------|
|   |                                       | Copay Plan                     |                                     |
|   |                                       | Pediatric Dental EHB           | Adult Dental                        |
|   |                                       | Up to Age 19                   | Age 19 and Older                    |
| <b>Actuarial Value</b>  |                                       | 83.2%                          | Not Calculated                      |
|   |                                       | In-Network                     | In-Network                          |
| <b>Individual Deductible</b>  |                                       | None                           | None                                |
| <b>Family Deductible (Two or more children)</b>   |                                       | Not applicable                 | Not Applicable                      |
| <b>Individual Out of Pocket Maximum</b>   |                                       | \$350                          | Not Applicable                      |
| <b>Family Out of Pocket Maximum (Two or More Children)</b>  |                                       | \$700                          | Not Applicable                      |
| <b>Office Copay</b>   |                                       | \$0                            | \$0                                 |
| <b>Waiting Period</b><br><small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small> |                                       | None                           | None                                |
| <b>Annual Benefit Limit</b><br><small>(the maximum amount the dental plan will pay in the benefit year)</small>   |                                       | None                           | None                                |
| Procedure Category  | Service Type                          | Member Cost Share              | Member Cost Share                   |
| <b>Diagnostic &amp; Preventive</b>  | Oral Exam                             | No charge                      | No charge                           |
|   | Preventive - Cleaning                 | No charge                      | No charge                           |
|   | Preventive - X-ray                    | No charge                      | No charge                           |
|   | Sealants per Tooth                    | No charge                      | <del>Not Covered</del><br>No Charge |
|   | Topical Fluoride Application          | No charge                      | <del>Not Covered</del><br>No Charge |
|   | Space Maintainers - Fixed             | No charge                      | <del>Not Covered</del><br>No Charge |
| <b>Basic Services</b>   | Restorative Procedures                | See 2018 Dental Copay Schedule | See 2018 Dental Copay Schedule      |
|   | Periodontal Maintenance Services      |                                |                                     |
| <b>Major Services</b>   | Periodontics (other than maintenance) | See 2018 Dental Copay Schedule | See 2018 Dental Copay Schedule      |
|   | Endodontics                           |                                |                                     |
|   | Crowns and Casts                      |                                |                                     |
|   | Prosthodontics                        |                                |                                     |
|   | Oral Surgery                          |                                |                                     |
| <b>Orthodontia</b>  | Medically Necessary Orthodontia       | \$350                          | Not Covered                         |



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| Covered California for Small Business   |                                       |                              |                              |                              |                              |
|---|---------------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Group Dental Plan   |                                       |                              |                              |                              |                              |
| Coinsurance Plan  |                                       |                              |                              |                              |                              |
| Pediatric Dental EHB  |                                       |                              | Adult Dental                 |                              |                              |
| Up to Age 19  |                                       |                              | Age 19 and Older             |                              |                              |
| Actuarial Value   |                                       | 86.8%                        | 86.8%                        | Not Calculated               | Not Calculated               |
|   |                                       | In-Network                   | Out-of-Network               | In-Network                   | Out-of-Network               |
| <b>Individual Deductible</b>  |                                       | \$65                         | \$65                         | \$50                         | \$50                         |
| <b>Family Deductible (Two or more children)</b>   |                                       | \$130                        | \$130                        | Not Applicable               | Not Applicable               |
| <b>Individual Out of Pocket Maximum</b>   |                                       | \$350                        | None                         | Not Applicable               | Not Applicable               |
| <b>Family Out of Pocket Maximum (Two or More Children)</b>  |                                       | \$700                        | None                         | Not Applicable               | Not Applicable               |
| <b>Office Copay</b>   |                                       | \$0                          | \$0                          | \$0                          | \$0                          |
| <b>Waiting Period</b><br><small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small> |                                       | None                         | None                         | None                         | None                         |
| <b>Annual Benefit Limit</b><br><small>(the maximum amount the dental plan will pay in the benefit year)</small>   |                                       | None                         | None                         | \$1,500                      |                              |
| Procedure Category  | Service Type                          | Member Cost Share            | Member Cost Share            | Member Cost Share            | Member Cost Share            |
| <b>Diagnostic &amp; Preventive</b>  | Oral Exam                             | No charge                    | 10%                          | No charge                    | 10%                          |
|   | Preventive - Cleaning                 | No charge                    | 10%                          | No charge                    | 10%                          |
|   | Preventive - X-ray                    | No charge                    | 10%                          | No charge                    | 10%                          |
|   | Sealants per Tooth                    | No charge                    | 10%                          | Not Covered<br>No Charge     | Not Covered<br>10%           |
|   | Topical Fluoride Application          | No charge                    | 10%                          | Not Covered<br>No Charge     | Not Covered<br>10%           |
|   | Space Maintainers - Fixed             | No charge                    | 10%                          | Not Covered<br>No Charge     | Not Covered<br>10%           |
| <b>Basic Services</b>   | Restorative Procedures                | 20%                          | 30%                          | 20%                          | 30%                          |
|   | Periodontal Maintenance Services      | Deductible Applies           | Deductible Applies           | Deductible Applies           | Deductible Applies           |
| <b>Major Services</b>   | Periodontics (other than maintenance) | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies |
|   | Endodontics                           |                              |                              |                              |                              |
|   | Crowns and Casts                      |                              |                              |                              |                              |
|   | Prosthodontics                        |                              |                              |                              |                              |
| <b>Orthodontia</b>  | Oral Surgery                          | 50%<br>Deductible<br>Applies | 50%<br>Deductible<br>Applies | Not Covered                  | Not Covered                  |
|   | Medically Necessary Orthodontia       |                              |                              |                              |                              |

## **Endnotes to 2018 Dental Standard Benefit Plan Designs**

### **Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)**

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Deductible is waived for Diagnostic and Preventive Services.
- 3) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
- 5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
- 6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- 7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 8) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

### **Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)**

- 9) Each adult is responsible for an individual deductible.
- 10) Deductible is waived for Diagnostic and Preventive Services.
- 11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 12) Tooth whitening, adult orthodontia, implants and veneers are not covered services.

- 13) The six month waiting period for major services must be waived upon a member's provision of proof of prior comprehensive dental coverage. This waiting period shall be prorated on a one to one monthly basis upon a member's provision of proof of prior comprehensive dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month waiting period would no longer occur. Dental services obtained via a discount health plan are not considered "comprehensive" dental coverage for purposes of counting towards the waiting period.
- 14) The following CDT codes are not covered adult dental benefits: D0145, D0251, ~~D0310, D0320, D0322, D0340, D0350, D0351, D0601, D0602, D0603~~, D1120, ~~D1206, D1208, D1310, D1320~~, D1352, ~~D1520, D1525, D1575~~, D2929, D2930, D2932, D2933, D2941, D2949, D2955, D2971, D3230, D3240, D3353, D4920, D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5937, D5951, D5952, D5953, D5954, D5955, D5958, D5959, D5960, D5982, D5983, D5984, D5985, D5986, D5987, D5988, D5991, ~~D5999~~, D6010, D6011, D6013, D6040, D6050, D6052, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6081, D6085, D6090, D6091, D6092, D6093, D6094, D6095, D6100, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6190, D6194, D6199, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7952, D7955, D7972, D7990, D7991, D7995, D7997, D8080, ~~D8210, D8220, D8660, D8670, D8680, D8681, D8691, D8692, D8693, D8694, D8999~~, D9230, D9248, D9410, D9420, D9610, D9612, D9950