

General Dentist Check List

The following items must be submitted to CDN in order to process your application.

- Dental Services Agreement signed by OWNER dentist—no delegated signatures allowed (enclosed).
- Individual Dentist Information for OWNER dentist and signed by owner dentist only (enclosed).
- Dental Facility Information (enclosed)
- W-9 Request for Taxpayer Identification Number and Certification (enclosed)
- Signed Staff Credentialing Agreement—signed by OWNER dentist, listing all associates that work in the practice (enclosed).

For the OWNER DENTIST only:

- Copy of current Dental License
- Copy of current DEA Certificate
- Copy of current CPR Certificate
- Copy of current Malpractice Insurance Declaration Page

California Dental Network, Inc.

Dental Services Agreement **For General Dentist**

This Agreement is made and entered into this ____ day of _____, 20__ by and between California Dental Network, Inc., a California corporation, (hereinafter referred to as "CDN"), and _____ (hereinafter referred to as "DENTIST").

In consideration of the mutual covenants hereinafter contained, the parties hereby agree:

Declarations

CDN is a Health Care Service Plan licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 to provide or arrange for dental care to members enrolled under Individual or Group Subscriber Agreements.

DENTIST operates and maintains a dental practice in the State of California and wishes to treat CDN members as patients in his/her practice under the terms and conditions of such member's enrollment in CDN.

I. MEMBERS ELIGIBLE FOR SERVICES.

Members eligible for treatment by DENTIST under this Agreement shall be only those members covered under a group or individual subscriber agreement with CDN at the time dental services are rendered and who have selected DENTIST's facility to receive their dental care. CDN shall furnish DENTIST, from time to time, with an "eligibility list" of all members eligible for services under this Agreement and shall indicate the CDN benefit plan to which each member is entitled. Before rendering or refusing services to any person claiming to be a CDN member who is not on DENTIST's current month "eligibility list," DENTIST shall telephone CDN for verification of the member's enrollment and eligibility status.

II. RENDERING CARE TO ELIGIBLE MEMBERS.

DENTIST shall render all necessary dental services to each member eligible for service under this Agreement during DENTIST's regular office hours, and subject to DENTIST's usual appointment scheduling practices. Covered services shall be provided in accordance with the Principle Benefits, Principle Exclusions and Principle Limitations contained in the Group or Individual Subscriber Agreement under which the member is enrolled. DENTIST shall have the right, within the framework of professional ethics, to reject any patient seeking DENTIST's professional services, or limit the number of CDN members assigned to DENTIST.

DENTIST shall provide appointments to eligible members upon reasonable request, which shall not exceed two weeks for non-emergency cases. DENTIST shall also provide 24-hour emergency services and will arrange for coverage of emergencies during vacations and other periods which DENTIST's office is closed, or make other arrangements for such coverage at DENTIST's expense.

CDN shall be entitled to take whatever action it deems appropriate to obtain covered services for members within a reasonable time.

III. SERVICES NOT COVERED AND OTHER FEES DUE DIRECTLY FROM MEMBER.

In the cases where DENTIST provides dental services which are not covered under the Group or Individual Subscriber Agreement under which the member is enrolled, or which, under such agreements, all or a portion of the fees for the services provided are to be paid by the member as copayments, it is expressly agreed that DENTIST shall look solely to the member, or the member's responsible party, for payment of such amounts. CDN shall have no responsibility for the payment of non-covered services or patient copayments. DENTIST shall bill the member for non-covered services at a rate not to exceed the DENTIST's usual and customary fee for the services provided and copayments shall not exceed the amounts set forth in the member's Group or Individual Subscriber Agreement.

IV. PAYMENT TO DENTIST FOR SERVICES UNDER THIS AGREEMENT.

As payment in full for covered services under this Agreement, CDN shall pay DENTIST a fee based upon the number of **members eligible for services** under this Agreement, and other fees as set forth in Attachment A to this Agreement.

DENTIST shall look solely to CDN for payment of amounts due from CDN during the term of this Agreement and/or after termination. DENTIST acknowledges that Section 1379 of the Knox-Keene Health Care Service Plan Act prohibits providers, and agents or trustees thereof, from bringing any action at law against a member to collect amounts owed from a Health Care Service Plan.

DENTIST agrees that CDN has the right to deduct, offset or withhold from any payment(s) otherwise due DENTIST, amounts due from DENTIST through DENTIST's neglect or failure to fulfill any business or patient obligation that involves CDN's members, operations and/or obligations.

V. TREATMENT BY A SPECIALIST.

If, in the DENTIST's professional opinion, a member requires the services of a Specialist, and such referrals are covered under the member's Group or Individual Subscriber Agreement. DENTIST shall submit a completed CDN specialty referral form, along with all appropriate records and x-rays to CDN. If CDN's Dental Director agrees with the DENTIST's diagnosis, CDN shall refer the member to the proper specialist. If CDN's Dental Director disagrees with the DENTIST's diagnosis, CDN's Dental Director shall confer with DENTIST to discuss the diagnosis and the member's benefits, if applicable.

The costs of approved specialty referrals to a CDN designated Specialist shall be CDN's responsibility. DENTIST shall be responsible for the costs, in excess of the member's copayment for specialty referrals made by DENTIST when CDN has denied such referrals. DENTIST shall also be responsible for the costs incurred by the member in excess of what CDN would have paid to a CDN designated specialist for an approved referral, if DENTIST has referred the member to a non-CDN designated specialist.

VI. CHANGES IN THE TERMS AND BENEFITS OF THE GROUP AND INDIVIDUAL SUBSCRIBER AGREEMENTS.

It is expressly understood that the terms and conditions including, but not limited to, the benefits, exclusions and limitations of the various Group and Individual Subscriber Agreements, or in contracts between the group and its employees or members, may be changed from time to time during the term of this Agreement. Also, during the term of this Agreement, CDN may develop and market new benefit plans, which contain different benefits, exclusions and limitations than those currently used by CDN. In such cases, CDN shall notify DENTIST in writing of the nature and extent of such changes, or new benefit plans. Except for material changes in the types of plans or levels of benefits pursuant to section XVIII, DENTIST shall have ten days after receipt of said notice to review the changes or new benefit plans. If DENTIST does not notify CDN of his/her election not to treat members enrolled under such revised or new benefit plans within this ten-day period, DENTIST shall be bound by, and agree to provide services under this Agreement to members enrolled under such revised or new benefit plans.

VII. DURATION AND TERMINATION OF AGREEMENT.

This Agreement shall be for a period of one year from CDN's approval date, indicated below, and shall automatically renew for additional one-year periods until terminated. Either party may terminate this Agreement, at any time, by giving a 60-day written notice to the other party by registered or certified mail. Notwithstanding this provision, CDN may terminate this Agreement, immediately upon notice to DENTIST if DENTIST materially fails to comply with this Agreement or CDN's Quality Assurance requirements, or fails to maintain adequate insurance as required under Section XI of this Agreement.

VIII. OBLIGATIONS AFTER NOTICE AND TERMINATION OF AGREEMENT.

In the event notice of termination is given, by either party, DENTIST shall continue to render covered dental services and treat members in accordance with this Agreement, as if notice was not given, until the date this Agreement terminates. DENTIST shall, at the time a member seeks an appointment and again prior to rendering dental services, notify each member that he/she has given notice of termination with the effective date, or is no longer a participating CDN provider, whichever the case may be at such time. DENTIST shall not render any covered dental services to CDN members after the date this Agreement terminates, except that, DENTIST shall complete all work started prior to the termination date in accordance with the provisions of this Agreement. DENTIST agrees to forward copies of all patient records and x-rays within 30 days of a request from a member or the member's new dentist.

Termination of this Agreement does not relieve DENTIST of the responsibilities to maintain insurance and indemnify CDN and its agents as set forth in Section XI, to maintain and provide access to books and records as set forth in Section XIII, or to the dispute resolution procedures set forth in Section XVII of this Agreement.

IX. STANDARD OF DENTIST CARE.

DENTIST agrees that all services rendered to members under this Agreement shall be in accordance with the high standards of the dental profession for competence, care and concern for the welfare and needs of each member as set forth in the ‘Principals of Ethics of the American Dental Association’ and the ‘Dental Practice Act’ of the State of California. DENTIST will not discriminate in the treatment of member patients and agrees to provide services to members equal in all respects to those provided to non-member patients of his/her practice. Furthermore, DENTIST shall not discriminate against any group or member, or prospective group or member, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age.

X. DENTIST-PATIENT RELATIONSHIP.

DENTIST shall maintain the dentist-patient relationship with each member eligible for services under this Agreement and shall be solely responsible to such members for any dental advice and/or treatment. It is expressly agreed between the parties that DENTIST is an independent contractor and that neither the member, CDN, nor any group contracting with CDN shall control or dominate the DENTIST’s practice, practice personnel, facilities or the dentist-patient relationship.

XI. INSURANCE AND INDEMNIFICATION.

DENTIST agrees to carry, at all times during the term of this Agreement and for at least seven years thereafter, such policies of professional liability and other insurance as shall be necessary to insure DENTIST and DENTIST’s employees, agents, associates or affiliates against any claim(s) for damages, personal injury or death caused directly or indirectly in connection with the provision of services, lack of services, or the uses of any property, facilities or equipment under this Agreement. DENTIST shall provide CDN with ‘Certificates of Insurance’ from DENTIST’s insurance carrier(s) to evidence the existence of such coverage(s) in amounts acceptable to CDN. Failure to maintain such insurance is grounds for CDN to immediately terminate this Agreement. CDN may provide copies of such certificate(s) to any group or potential group upon request. DENTIST hereby agrees to indemnify and hold harmless CDN and any of CDN’s officers, directors, agents, representatives and/or employees from and against all claims, suits, demands, actions, losses, liabilities and expenses, (including, without limitation, actual legal fees and expenses), that may arise out of any; (1) act or omission by DENTIST or any of DENTIST’s employees, agents, associates, or affiliates in connection with any dental services, lack of services, or the uses of any property, facilities or equipment pursuant to this Agreement; (2) breach or failure of DENTIST or DENTIST’s employees, agents, associates, or affiliates to perform any representation, warranties, covenants or term(s) of this Agreement; (3) liability of DENTIST, whether contingent, absolute, direct, indirect, matured or unmatured.

XII. PROHIBITION OF SURCHARGES.

Dentist shall not surcharge members for covered services. A surcharge, as used herein, is an additional fee which is charged to a member for a covered service but which is not approved by the Department of Managed Health Care, or provided for in the Group or Individual Subscriber Agreement under which the member is enrolled. DENTIST must report in writing to CDN all copayments and surcharges paid by members to DENTIST, unless the Department of Managed Health Care expressly approves otherwise.

XIII. RECORDS AND REPORTS.

DENTIST shall maintain such records and provide such information to CDN or the Department of Managed Health Care as may be necessary for CDN to comply with the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder. Such records shall be retained for a period of at least five years, the last two years of which shall be in an easily accessible place at DENTIST’s office. CDN and/or the Department of Managed Health Care shall have access, during normal business hours and with reasonable notice to the books and records, including financial records, and documents of DENTIST relating to the dental services provided to CDN members, to the cost of such services and to payments received by DENTIST from CDN members, or from others on the members’ behalf.

XIV. DENTIST PARTICIPATION IN CDN COMMITTEES AND POLICIES.

DENTIST agrees to cooperate with, participate in and abide by CDN’s policies and procedures regarding the administration of its plan, including but not limited to CDN’s Quality Assurance and Peer Review Programs, Grievance Resolution Process, Public Policy Participation System, and the Plan’s Language Assistance Program Standards.”

XV. NON-EXCLUSIVE.

This Agreement is not exclusive in any respect and CDN may enter into similar agreements with other dentists, and DENTIST is entitled to enter into similar agreements with other plans.

XVI. ASSIGNABILITY.

This Agreement is intended to secure the personal services of DENTIST, and his/her associates, and therefore may not be assigned or transferred without the written consent of CDN.

XVII. DISPUTE RESOLUTION.

The Plan maintains a provider dispute resolution process to deal with all provider complaints. Any disputes or complaints shall be made to CDN in writing or contacting CDN at the address and telephone number indicated herein. Providers will receive a written response within 30 days as to the disposition of the complaint. Appeal of the decisions regarding the provider's complaint may be made in writing to the Plan's Public Policy or Quality Assurance Committee. If the provider is not satisfied with the Public Policy or Quality Assurance Committee's decision, the provider may pursue binding arbitration in accordance with the rules of the American Arbitration Association. Arbitration shall be held in Orange County, California and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The prevailing party shall be entitled to recover its costs and reasonable attorneys' fees. In addition, DENTIST agrees to comply with any and all arbitration proceedings initiated by members involving CDN, a CDN contractor or CDN employee, agent or representative.

XVIII. GOVERNING LAW.

The parties agree that the laws of the State of California shall govern the validity, construction and interpretation of this Agreement. DENTIST agrees that any amendment to this agreement or any of CDN's manuals, policies or procedures required to meet state or federal laws or regulations governing Knox-Keene Health Care Service Plans, or any accreditation requirements of a private sector accreditation organization to which CDN participates, shall automatically become part of this Agreement. In the event of any inconsistency between this agreement and such laws, regulations or accreditation requirements, the applicable laws, regulations or accreditation requirements shall prevail over any provision of this Agreement. In the event a court or arbitrator(s) with component jurisdiction determines that any provision of this Agreement is invalid, for any reason, the remaining provisions of this Agreement shall be binding upon the parties.

XIX. ENTIRE AGREEMENT.

This Agreement along with any amendments and attachments, constitutes the sole and entire contract and understanding between the parties with respect to the subject matter hereto and no amendment to this agreement shall be effective unless it is in writing and signed by an authorized representative of CDN. CDN may from time to time amend this agreement by providing DENTIST with a 30 day written notice of the changes. Except as set forth in Section XVIII, CDN shall not make any material change to this agreement or its manuals, policies or procedures without providing DENTIST with a notice of the changes, at least 45 business days before the effective date of the change. DENTIST has the right to negotiate and agree to the changes during the notice periods. If CDN and DENTIST cannot agree with the changes, DENTIST may terminate this agreement prior to the effective date of any change.

NOTICES.

Any notice or other communication required or permitted hereunder shall be in writing, and shall be deemed to have given if personally delivered or 24 hours after it is placed in the United States mail, first class postage-paid addressed to:

DENTIST:

CDN:

Stephen R. Casey, President
California Dental Network, Inc.
1971 E. 4th Street, Suite 184
Santa Ana, CA 92705-3917

In witness whereof, the parties hereto have entered into this Agreement as of the date indicated above.

DENTIST: _____

Print Name

Signature: _____

Date: _____

SSN or Federal Tax ID #: _____

CALIFORNIA DENTAL NETWORK, INC.

Signature: _____

Name/Title: Stephen R. Casey, President

Approval Date: _____

Attachment A

Providers are not required to participate in all Benefit plans! You may choose to participate in only the Benefit Plans that you select.

Please initial below the Benefit Plans in which your office wishes to participate.

<u>Benefit Plans</u>										
100	340*	530	430	501	460/465**	411	300	665	600	505/595***
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
			404/495	303/395	A75	A100	A150	A200	A250	
			_____	_____	_____	_____	_____	_____	_____	

Compensation:

Plans 100, 340, 530, 430, 501, & 460 are Discounted Fee-For-Service Plans which are co payment only, non-capitation plans. For ALL other plans California Dental Network will pay you the following monthly capitation payments for each family selecting your office for their general dentistry:

	<u>Single</u>	<u>Couple</u>	<u>Family</u>
Plan 465.....	\$2.50.....	\$4.50.....	\$6.50
Plan 411.....	\$6.50.....	\$8.50.....	\$11.50
Plan 300			
Individuals & Groups Under 50 Members.....	\$2.75.....	\$4.50.....	\$7.00
Groups of 50 or More Members	\$2.00.....	\$4.00.....	\$6.00
Plan 665.....	\$4.75.....	\$7.50.....	None
Plan 600.....	\$4.50.....	\$7.50.....	\$10.00
Plan 454+.....	\$4.25.....	\$7.25.....	\$10.00
Plan 505/595+			
Individuals & Groups Under 50 Members.....	\$4.95.....	\$8.30.....	\$12.25
Groups of 50 or More Members	\$4.00.....	\$7.00.....	\$9.50
Plan 404/495+			
Individuals & Groups Under 50 Members.....	\$6.00.....	\$11.12.....	\$16.75
Groups of 50 or More Members	\$5.75.....	\$10.62.....	\$16.50
Plan 303/395+.....	\$6.50.....	\$11.50.....	\$17.50
Plan 309+.....	\$6.50.....	\$11.50.....	\$17.50

	<u>Northern California*</u>			<u>Southern California*</u>		
	<u>Single</u>	<u>Couple</u>	<u>Family</u>	<u>Single</u>	<u>Couple</u>	<u>Family</u>
UABT Basic	None	None	None	None	None	None
UABT Choice	\$3.50	\$5.50	\$7.50	\$2.50	\$4.50	\$6.50
UABT Prime+	\$5.50	\$9.00	\$11.50	\$4.00	\$7.00	\$9.50

*CDN considers Southern California to be Ventura, Los Angeles, San Bernardino, Orange, Kern, Riverside, San Diego, and Imperial Counties. All others are defined as Northern California for CDN purposes.

	<u>A75</u>	<u>A100</u>	<u>A150</u>	<u>A200</u>	<u>A250</u>
Employee Only	\$6.50	\$5.00	\$4.50	\$4.00	\$2.50
With Spouse*	\$11.00	\$9.50	\$8.00	\$7.00	\$5.00
With Children	\$12.00	\$10.50	\$9.00	\$8.00	\$5.00
With Family	\$17.00	\$14.00	\$12.50	\$11.00	\$7.50

+The Plan will reimburse you for your lab costs under group plans to the following maximums:

Crowns & Bridges, per unit, \$40.00
Dentures & Partials, \$90.00

Except for members enrolled in Advantage Plans, providers may charge members, in addition to lab reimbursements, the actual lab costs for gold utilized in each crown or bridge unit.

* Also sold as UABT Basic
**Also sold as UABT Choice
*** Also sold as UABT Prime

Attachment B - Page 1

Summary of Benefit Plans, Copayments

	<u>Plan 100</u>	<u>Plan 340</u>	<u>Plan 530</u>	<u>Plan 430</u>	<u>Plan 460/465</u>	<u>Plan 501</u>	<u>Plan 411</u>
Office Visit	No Charge	\$10.00	\$5.00	\$5.00	\$5.00	\$5.00	No Charge
D120 Periodoc Oral Examination	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
<u>X-Rays</u>							
D210 Intraoral, Complete Series	No Charge	\$15.00	No Charge	No Charge	No Charge	No Charge	No Charge
D270 Bitewing, Single Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D330 Panoramic Film	No Charge	\$10.00	No Charge	No Charge	No Charge	No Charge	No Charge
<u>Prophylaxis</u>							
D1110 Adult	No Charge	\$25.00	No Charge	No Charge	No Charge	No Charge	No Charge
D1120 Child	No Charge	\$15.00	No Charge	No Charge	No Charge	No Charge	No Charge
<u>Amalgam Fillings</u>							
D2140 1 Surface	\$22.00	\$30.00	\$22.00	\$20.00	\$10.00	\$25.00	\$15.00
D2150 2 Surfaces	\$28.00	\$50.00	\$28.00	\$25.00	\$15.00	\$32.00	\$20.00
D2160 3 Surfaces	\$38.00	\$60.00	\$38.00	\$34.00	\$20.00	\$42.00	\$26.00
D2161 4 or More Surfaces	\$48.00	\$70.00	\$48.00	\$43.00	\$25.00	\$53.00	\$34.00
<u>Resin Fillings</u>							
D2330 1 Surface, Anterior	\$35.00	\$35.00	\$35.00	\$35.00	\$25.00	\$38.00	\$25.00
D2331 2 Surfaces, Anterior	\$35.00	\$55.00	\$35.00	\$35.00	\$25.00	\$76.00	\$25.00
D2332 3 Surfaces, /anterior	\$35.00	\$65.00	\$35.00	\$35.00	\$25.00	\$114.00	\$25.00
D2335 4 or More Surfaces, Anterior	\$37.00	\$75.00	\$37.00	\$37.00	\$40.00	\$164.00	\$28.00
D2391 1 Surface, Posterior	\$39.00	\$85.00	\$45.00	\$45.00	\$50.00	\$125.00	\$30.00
<u>Crowns</u>							
D2750 PFM, High Noble	\$220.00	\$400.00	\$220.00	\$200.00	\$275.00	\$280.00	\$165.00
D2750 PFM, Molars	\$295.00	\$475.00	\$275.00	\$275.00	\$350.00	\$390.00	\$250.00
<u>Root Canals</u>							
D3310 Anterior	\$138.00	\$200.00	\$138.00	\$125.00	\$125.00	\$145.00	\$100.00
D3320 Bicuspid	\$165.00	\$275.00	\$165.00	\$150.00	\$150.00	\$185.00	\$130.00
D3330 Molar	\$204.00	\$350.00	\$204.00	\$185.00	\$185.00	\$225.00	\$175.00
<u>Dentures</u>							
D5110-20 Complete Upper or Lower	\$308.00	\$500.00	\$308.00	\$280.00	\$350.00	\$385.00	\$250.00
D5130-40 Immediate Upper or Lower	\$308.00	\$500.00	\$308.00	\$280.00	\$350.00	\$385.00	\$250.00
D5211, 12 Resin Partial Upper or Lower	\$275.00	\$450.00	\$275.00	\$250.00	\$300.00	\$275.00	\$225.00
D5213, 14 Metal Partial Upper or Lower	\$308.00	\$500.00	\$308.00	\$280.00	\$350.00	\$385.00	\$255.00
<u>Extractions</u>							
D7111 Coronal Remnants	\$21.00	\$50.00	\$21.00	\$19.00	\$25.00	\$28.00	\$19.00
D7140 Erupted Tooth	\$21.00	\$50.00	\$21.00	\$19.00	\$25.00	\$28.00	\$19.00
<u>Surgical Extractions</u>							
D7220 Impacted Soft Tissue	\$65.00	\$100.00	\$65.00	\$60.00	\$60.00	\$68.00	\$50.00
D7230 Impacted Partially Bony	70% UCR	\$145.00	\$93.00	\$75.00	\$75.00	\$95.00	\$65.00
D7240 Impacted Completely Bony	70% UCR	\$175.00	\$110.00	\$100.00	\$100.00	70% UCR	\$90.00

Attachment B - Page 2

Summary of Benefit Plans, Copayments

	<u>Plan 300</u>	<u>Plan 665</u>	<u>Plan 600</u>	<u>Plan 454</u>	<u>Plan 505/595</u>	<u>Plan 404/495</u>	<u>Plan 303/395</u>	<u>Plan 309</u>
Office Visit	No Charge	\$4.00	\$6.00	No Charge	No Charge	No Charge	No Charge	UCR
D120 Periodoc Oral Examination	No Charge	No Charge	No Charge	\$5.00	No Charge	No Charge	No Charge	No Charge
<u>X-Rays</u>								
D210 Intraoral, Complete Series	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D270 Bitewing, Single Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D330 Panoramic Film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
<u>Prophylaxis</u>								
D1110 Adult	No Charge	UCR	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
D1120 Child	No Charge	\$10.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
<u>Amalgam Fillings</u>								
D2140 1 Surface	\$9.00	\$10.00	No Charge	No Charge	\$4.00	\$2.00	No Charge	No Charge
D2150 2 Surfaces	\$14.00	\$17.00	No Charge	No Charge	\$5.00	\$3.00	No Charge	No Charge
D2160 3 Surfaces	\$25.00	\$22.00	No Charge	No Charge	\$6.00	\$4.00	No Charge	No Charge
D2161 4 or More Surfaces	\$35.00	\$27.00	No Charge	No Charge	\$8.00	\$5.00	No Charge	No Charge
<u>Resin Fillings</u>								
D2330 1 Surface, Anterior	\$25.00	\$25.00	\$14.00	\$5.00	\$14.00	\$10.00	\$10.00	No Charge
D2331 2 Surfaces, Anterior	\$35.00	\$35.00	\$14.00	\$10.00	\$14.00	\$10.00	\$10.00	No Charge
D2332 3 Surfaces, /anterior	\$40.00	\$45.00	\$14.00	\$15.00	\$14.00	\$10.00	\$10.00	No Charge
D2335 4 or More Surfaces, Anterior	\$50.00	\$55.00	\$14.00	\$20.00	\$16.00	\$12.00	\$12.00	No Charge
D2391 1 Surface, Posterior	\$60.00	\$35.00	\$35.00	\$30.00	\$18.00	\$14.00	\$14.00	\$65.00
<u>Crowns</u>								
D2750 PFM, High Noble	\$200.00	\$285.00	\$285.00	\$140.00	\$156.00	\$105.00	\$90.00	\$50.00
D2750 PFM, Molars	\$275.00	\$375.00	\$375.00	\$240.00	\$236.00	\$185.00	\$170.00	\$50.00
<u>Root Canals</u>								
D3310 Anterior	\$100.00	\$95.00	\$75.00	\$55.00	\$80.00	\$45.00	\$35.00	\$70.00
D3320 Bicuspid	\$135.00	\$150.00	\$150.00	\$90.00	\$100.00	\$90.00	\$70.00	\$80.00
D3330 Molar	\$185.00	\$250.00	\$225.00	\$150.00	\$140.00	\$130.00	\$105.00	\$150.00
<u>Dentures</u>								
D5110-20 Complete Upper or Lower	\$200.00	\$370.00	\$370.00	\$140.00	\$160.00	\$90.00	\$70.00	\$100.00
D5130-40 Immediate Upper or Lower	\$225.00	\$370.00	\$370.00	\$140.00	\$160.00	\$90.00	\$70.00	\$100.00
D5211, 12 Resin Partial Upper or Lower	\$200.00	\$295.00	\$340.00	UCR	\$150.00	\$70.00	\$50.00	\$100.00
D5213, 14 Metal Partial Upper or Lower	\$200.00	\$350.00	\$395.00	\$140.00	\$175.00	\$90.00	\$70.00	\$100.00
<u>Extractions</u>								
D7111 Coronal Remnants	\$10.00	\$20.00	\$10.00	\$5.00	\$10.00	\$5.00	No Charge	No Charge
D7140 Erupted Tooth	No Charge	\$20.00	No Charge	\$5.00	\$10.00	\$5.00	No Charge	No Charge
<u>Surqical Extractions</u>								
D7220 Impacted Soft Tissue	\$60.00	\$55.00	\$45.00	\$32.00	\$40.00	\$30.00	No Charge	\$30.00
D7230 Impacted Partially Bony	\$75.00	\$70.00	\$60.00	\$50.00	\$50.00	\$40.00	No Charge	\$60.00
D7240 Impacted Completely Bony	\$100.00	UCR	UCR	\$75.00	\$75.00	\$50.00	No Charge	UCR

**Attachment B--Page 3
Summary of Benefit Plans, Copayments**

	<u>UABT Basic</u>	<u>UABT Prime</u>	<u>UABT Choice</u>
<u>Office Visit</u>	\$10.00	\$5.00	No Charge
D120 Periodic Oral Examination	No Charge	No Charge	No Charge
<u>X-Rays</u>			
D210 Intraoral, Complete Series	\$15.00	No Charge	No Charge
D270 Bitewing, Single Film	No Charge	No Charge	No Charge
D330 Panoramic Film	\$10.00	No Charge	No Charge
<u>Prophylaxis</u>			
D1110 Adult	\$25.00	No Charge	No Charge
D1120 Child	\$15.00	No Charge	No Charge
<u>Amalgam Fillings</u>			
D2140 1 Surface	\$30.00	\$10.00	\$4.00
D2150 2 Surfaces	\$50.00	\$15.00	\$5.00
D2160 3 Surfaces	\$60.00	\$20.00	\$6.00
D2161 4 or More Surfaces	\$70.00	\$25.00	\$8.00
<u>Resin Fillings</u>			
D2330 1 Surface, Anterior	\$35.00	\$25.00	\$14.00
D2331 2 Surfaces, Anterior	\$55.00	\$25.00	\$14.00
D2332 3 Surfaces, /anterior	\$65.00	\$25.00	\$14.00
D2335 4 or More Surfaces, Anterior	\$75.00	\$40.00	\$16.00
D2391 1 Surface, Posterior	\$85.00	\$50.00	\$18.00
<u>Crowns</u>			
D2750 PFM, High Noble	\$400.00	\$275.00	\$156.00
D2750 PFM, Molars	\$475.00	\$350.00	\$236.00
<u>Root Canals</u>			
D3310 Anterior	\$200.00	\$125.00	\$80.00
D3320 Bicuspid	\$275.00	\$150.00	\$100.00
D3330 Molar	\$350.00	\$185.00	\$140.00
<u>Dentures</u>			
D5110-20 Complete Upper or Lower	\$500.00	\$350.00	\$160.00
D5130-40 Immediate Upper or Lower	\$500.00	\$350.00	\$160.00
D5211, 12 Resin Partial Upper or Lower	\$450.00	\$300.00	\$150.00
D5213, 14 Metal Partial Upper or Lower	\$500.00	\$350.00	\$175.00
<u>Extractions</u>			
D7111 Coronal Remnants	\$50.00	\$25.00	\$10.00
D7140 Erupted Tooth	\$50.00	\$25.00	\$10.00
<u>Surgical Extractions</u>			
D7220 Impacted Soft Tissue	\$100.00	\$60.00	\$40.00
D7230 Impacted Partially Bony	\$145.00	\$75.00	\$50.00
D7240 Impacted Completely Bony	\$175.00	\$100.00	\$75.00

Advantage Plans

California Dental Network is pleased to announce the introduction of a new series of prepaid plans called the **ADVANTAGE** PLANS. We believe these plans will add value to your practice and aid you and your staff in presenting treatment to members while at the same time, eliminating some of the member's confusion about their covered benefits and the cost of their treatment.

Some of the Advantages of these plans are:

1. We have eliminated the "Plus the cost of Gold" for PFM crown and have added to the cost of the base metal crown a fee of \$100 for "Noble" metal and \$150 for "High Noble" metal. These increased amounts are reflected in the co payments listed in the schedule of benefits, thus eliminating what some members claim are hidden charges.
2. We have added a substantial number of procedures to the list of covered services to enhance the member's benefits and we have set the co payments for many of these procedures at or close to what the member's cost would be using the traditional optional treatment formula. This will simplify your office's treatment presentation to the members and substantially reduce the number of times your staff has to explain why certain services are not covered when presenting optional treatment. An example of this are resin composite fillings on posterior teeth which are now covered benefits under the **ADVANTAGE** PLANS, but for substantially higher co payments. Other examples are 4263 - bone grafts, 4381 - localized antimicrobial agents (Arestin) and 4249 - Crown Lengthening.
3. Likewise, we have added to the list of covered services certain name brand crowns and dentures at co payment that are significantly higher than their traditional counterparts. This will allow dental offices that offer these name brand products to simply point to the member's co payment schedule for the amounts and it will eliminate the need for your staff to explain why your recommended name brand product is not a covered benefit.
4. We have added some cosmetic services such as labial veneers and bleaching for what we believe you will find to be agreeable fees.

We have also made a few changes and additions to the specialty referral and orthodontic services covered in the new **ADVANTAGE** PLANS as well.

Enclosed is a copy of the Schedule of Benefits for the new **ADVANTAGE** PLANS (10/2006). Pursuant to section VI of your "Dental Service Agreement for General Dentists" with California Dental Network, these new plans will be added to the list of benefit plans your office accepts.

Notice of Provider Compensation for Advantage Plans
Attachment A – Provider Compensation
to Dental Service Agreement for General Dentists

Monthly Capitation:

Capitation is a percentage of the member’s premiums that is paid to you on the first of each month for each member that has selected or been assigned to your office. Capitation may vary for each member, as their premiums vary based upon group size, employer contribution, location and other underwriting factors. However, California Dental guarantees that the monthly capitation **will not be less than** the following amounts:

	<u>75</u>	<u>100</u>	<u>150</u>	<u>200</u>	<u>250</u>
Employee Only	\$ 6.50	\$ 5.00	\$ 4.50	\$ 4.00	\$ 2.50
With Spouse*	\$ 11.00	\$ 9.50	\$ 8.00	\$ 7.00	\$ 5.00
With Children	\$ 12.00	\$ 10.50	\$ 9.00	\$ 8.00	\$ 5.00
With Family	\$ 17.00	\$ 14.00	\$ 12.50	\$ 11.00	\$ 7.50

* In three tiered rates Employee with one child are paid as employee with spouse

Lab Reimbursement:

In addition to other compensation, California Dental will reimburse providers for each crown, partial or denture provided to Group Members. Providers must submit a copy of a lab invoice showing the member’s name, the type of crown, partial or denture, the tooth or area involved and the lab cost, to California Dental, within one year of the date of service and California Dental will reimburse the provider \$40.00 per crown (Unit) and \$90.00 per denture to help offset their lab costs.

Member Copayments:

The advantage Plans have been designed to balance the members concern for cost with the providers need for compensation. Most plans have a balance of little to no copayments on things like preventive services and higher copayments on the more time consuming procedures such as crowns and bridges. As the benefit plans get richer, meaning lower overall copayments, the capitation amount increase, so remember, copayments are not the only form of provider compensation. Also, the plans include many procedures that would be optional treatment at substantially higher copayments.

It is customary for members to pay their copayments at the time services are rendered, the way any other patients would pay for their services. Any installment payment arrangements are up to the discretion of the individual dental office and not an issue the Plan will be involved, except that members have to receive proper credit for any charges relating to services that eventually are not preformed, for whatever reason.

If you have any questions, please call our Provide Relations Department.

Schedule of Benefits

75 100 150 200 250

The following procedures are covered benefits when performed by a California Dental participating dentist and are subject to exclusion, limitations and administrative policies, which are detailed in the Plan's Combined Evidence of Coverage and Disclosure Form.

If you have any questions about your eligibility, the Plan benefits or need assistance in selecting a dentist, please call California Dental's Customer Service Department, toll-free at:
(877) 4DENTAL

Please discuss all treatment options with your dentist before starting treatment.
Failure to do so may limit the patient's options once treatment has started.

Code	Description	Copayments				
Diagnostic Services						
D0120	Periodic oral evaluation	\$0	\$0	\$0	\$0	\$0
D0140	Limited oral evaluation - problem focused	\$0	\$0	\$0	\$0	\$0
D0150	Comprehensive oral evaluation - new or established patient	\$0	\$0	\$0	\$0	\$0
D0170	Re-evaluation - limited, problem focused	\$0	\$0	\$0	\$0	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	\$0	\$0	\$0	\$0	\$0
D0210	Intraoral - complete series (including bitewings)	\$0	\$0	\$0	\$0	\$0
D0220	Intraoral - periapical first film	\$0	\$0	\$0	\$0	\$0
D0230	Intraoral - periapical each additional film	\$0	\$0	\$0	\$0	\$0
D0240	Intraoral - occlusal film	\$0	\$0	\$0	\$0	\$0
D0250	Extraoral - first film	\$0	\$0	\$0	\$0	\$0
D0260	Extraoral - each additional film	\$0	\$0	\$0	\$0	\$0
D0270	Bitewing - single film	\$0	\$0	\$0	\$0	\$0
D0272	Bitewings - two films	\$0	\$0	\$0	\$0	\$0
D0274	Bitewings - four films	\$0	\$0	\$0	\$0	\$0
D0277	Vertical bitewings - 7 to 8 films	\$0	\$0	\$0	\$0	\$0
D0330	Panoramic film	\$0	\$0	\$0	\$0	\$0
D0350	Oral/facial photographic images	\$0	\$0	\$0	\$0	\$0
D0460	Pulp vitality tests	\$0	\$0	\$0	\$0	\$0
D0470	Diagnostic casts	\$0	\$0	\$0	\$0	\$0

Code	Description	Copayments				
<u>Preventive Services</u>						
* - Procedures limited to once every 6 months						
D1110	Prophylaxis - adult *	\$0	\$0	\$0	\$0	\$0
D1110	Prophylaxis - adult (each additional)	\$45	\$45	\$45	\$45	\$45
D1120	Prophylaxis - child *	\$0	\$0	\$0	\$0	\$0
D1120	Prophylaxis - child (each additional)	\$35	\$35	\$35	\$35	\$35
D1201	Topical application of fluoride (including prophylaxis) - child *	\$0	\$0	\$0	\$0	\$0
D1203	Topical application of fluoride (prophylaxis not included) - child *	\$0	\$0	\$0	\$0	\$0
D1204	Topical application of fluoride (prophylaxis not included) - adult *	\$0	\$0	\$0	\$0	\$0
D1205	Topical application of fluoride (including prophylaxis) - adult *	\$0	\$0	\$0	\$0	\$0
D1310	Nutritional counseling for control of dental disease	\$0	\$0	\$0	\$0	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0	\$0	\$0	\$0	\$0
D1330	Oral hygiene instructions	\$0	\$0	\$0	\$0	\$0
D1351	Sealant - per tooth	\$0	\$0	\$5	\$8	\$15
D1510	Space maintainer - fixed - unilateral	\$35	\$35	\$35	\$55	\$75
D1515	Space maintainer - fixed - bilateral	\$45	\$45	\$45	\$65	\$85
D1520	Space maintainer - removable - unilateral	\$35	\$35	\$35	\$55	\$75
D1525	Space maintainer - removable - bilateral	\$55	\$55	\$55	\$65	\$85
D1550	Re-cementation of space maintainer	\$0	\$0	\$0	\$10	\$10
<u>Restorative Services</u>						
D2140	Amalgam - 1 surface, primary or permanent	\$0	\$0	\$0	\$0	\$0
D2150	Amalgam - 2 surfaces, primary or permanent	\$0	\$0	\$0	\$0	\$0
D2160	Amalgam - 3 surfaces, primary or permanent	\$0	\$0	\$0	\$0	\$0
D2161	Amalgam - 4 or more surfaces, primary or permanent	\$0	\$0	\$0	\$0	\$0
D2330	Resin-based composite - 1 surface, anterior	\$0	\$10	\$10	\$10	\$20
D2331	Resin-based composite - 2 surfaces, anterior	\$0	\$12	\$15	\$20	\$30
D2332	Resin-based composite - 3 surfaces, anterior	\$0	\$14	\$20	\$25	\$40
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	\$0	\$20	\$25	\$30	\$50
D2390	Resin-based composite crown, anterior	\$50	\$75	\$85	\$90	\$100
D2391	Resin-based composite - 1 surface, posterior	\$65	\$65	\$70	\$75	\$80
D2392	Resin-based composite - 2 surfaces, posterior	\$85	\$85	\$100	\$110	\$120
D2393	Resin-based composite - 3 surfaces, posterior	\$100	\$100	\$125	\$140	\$150
D2394	Resin-based composite - 4 or more surfaces, posterior	\$120	\$120	\$150	\$170	\$185

Code	Description	Copolyments				
<u>Inlays/Onlays</u>						
D2510	Inlay - metallic - 1 surface	\$80	\$85	\$100	\$110	\$130
D2520	Inlay - metallic - 2 surfaces	\$85	\$90	\$105	\$120	\$140
D2530	Inlay - metallic - 3 or more surfaces	\$90	\$95	\$110	\$130	\$150
D2542	Onlay - metallic - 2 surfaces	\$85	\$90	\$105	\$130	\$150
D2543	Onlay - metallic - 3 surfaces	\$90	\$95	\$110	\$140	\$160
D2544	Onlay - metallic - 4 or more surfaces	\$95	\$100	\$115	\$150	\$170
D2610	Inlay - porcelain/ceramic - 1 surface	\$175	\$185	\$210	\$225	\$250
D2620	Inlay - porcelain/ceramic - 2 surfaces	\$195	\$200	\$225	\$250	\$275
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	\$210	\$215	\$240	\$265	\$300
D2642	Onlay - porcelain/ceramic - 2 surfaces	\$195	\$200	\$225	\$265	\$300
D2643	Onlay - porcelain/ceramic - 3 surfaces	\$205	\$215	\$240	\$280	\$315
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	\$210	\$225	\$250	\$290	\$325
D2650	Inlay - resin-based composite - 1 surface	\$70	\$75	\$90	\$100	\$110
D2651	Inlay - resin-based composite - 2 surfaces	\$75	\$80	\$95	\$105	\$115
D2652	Inlay - resin-based composite - 3 or more surfaces	\$80	\$85	\$100	\$110	\$120
D2662	Onlay - resin-based composite - 2 surfaces	\$75	\$80	\$95	\$100	\$130
D2663	Onlay - resin-based composite - 3 surfaces	\$80	\$85	\$100	\$110	\$135
D2664	Onlay - resin-based composite - 4 or more surfaces	\$85	\$90	\$105	\$115	\$140
<u>Crowns</u>						
Porcelian (tooth colored) crowns on molars cost \$75 extra per crown						
D2740	Crown - porcelain/ceramic substrate	\$225	\$250	\$300	\$350	\$400
D2750	Crown - porcelain fused to high noble metal	\$225	\$250	\$300	\$350	\$400
D2751	Crown - porcelain fused to predominantly base metal	\$75	\$100	\$150	\$200	\$250
D2752	Crown - porcelain fused to noble metal	\$175	\$200	\$250	\$300	\$350
D2780	Crown - 3/4 cast high noble metal	\$225	\$250	\$300	\$350	\$400
D2781	Crown - 3/4 cast predominantly base metal	\$75	\$100	\$150	\$200	\$250
D2782	Crown - 3/4 cast noble metal	\$175	\$200	\$250	\$300	\$350
D2783	Crown - 3/4 porcelain/ceramic	\$225	\$250	\$300	\$350	\$400
D2790	Crown - full cast high noble metal	\$225	\$250	\$300	\$350	\$400
D2791	Crown - full cast predominantly base metal	\$75	\$100	\$150	\$200	\$250
D2792	Crown - full cast noble metal	\$175	\$200	\$250	\$300	\$350
D2794	Crown - titanium	\$225	\$250	\$300	\$350	\$400
D2910	Recement inlay, onlay, or partial coverage restoration	\$0	\$0	\$0	\$10	\$15
D2915	Recement cast or prefabricated post and core	\$0	\$0	\$0	\$10	\$15
D2920	Recement crown	\$0	\$0	\$0	\$10	\$15
D2930	Prefabricated stainless steel crown - primary tooth	\$0	\$25	\$30	\$40	\$50
D2931	Prefabricated stainless steel crown - permanent tooth	\$0	\$35	\$40	\$40	\$50
D2940	Sedative filling	\$0	\$0	\$0	\$10	\$10
D2950	Core buildup, including any pins	\$0	\$10	\$20	\$20	\$20

Code	Description	Copayments				
D2951	Pin retention - per tooth, in addition to restoration	\$0	\$5	\$5	\$5	\$5
D2952	Cast post and core in addition to crown	\$50	\$50	\$50	\$65	\$75
D2953	Each additional cast post - same tooth	\$0	\$0	\$0	\$0	\$0
D2954	Prefabricated post and core in addition to crown	\$30	\$50	\$50	\$60	\$70
D2955	Post removal (not in conjunction with endodontic therapy)	\$15	\$15	\$25	\$35	\$35
D2957	Each additional prefabricated post - same tooth	\$0	\$0	\$0	\$0	\$0

Alternative Crowns

Most dental offices offer alternative to the porcelain/ceramic substrate and porcelain fused to metal crowns which are marketed under different brand names and maybe available through your California Dental participating provider for the following copayments:

Porcelain/ceramic substrate crown

Lava	\$650	\$700	\$750	\$750	\$750
Empress	\$600	\$650	\$700	\$750	\$750
Procera	\$650	\$700	\$750	\$750	\$750
In-Ceram	\$600	\$650	\$700	\$750	\$750

Porcelain fused to high noble crown

Captek	\$575	\$625	\$675	\$725	\$725
Bio - 2000	\$575	\$625	\$675	\$725	\$725
Ceramco II	\$600	\$625	\$675	\$725	\$725
Occlusal Gold	\$600	\$625	\$675	\$725	\$725

Call California Dental for a updated list of brand names covered

LABIAL Veneers (replaced once every 5 years)

D2961	Labial veneer (resin laminate) - laboratory	\$250	\$300	\$350	\$400	\$400
D2962	Labial veneer (porcelain laminate) - laboratory	\$250	\$300	\$350	\$400	\$400

Endodontics (excluding final restorations)

D3110	Pulp cap - direct	\$0	\$0	\$0	\$5	\$15
D3120	Pulp cap - indirect	\$0	\$0	\$0	\$5	\$15
D3220	Therapeutic pulpotomy	\$0	\$0	\$0	\$25	\$25
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth	\$10	\$10	\$10	\$30	\$40
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth	\$15	\$15	\$15	\$30	\$40
D3310	Root canal - anterior per tooth	\$50	\$75	\$100	\$115	\$125
D3320	Root canal - bicuspid per tooth	\$70	\$85	\$110	\$130	\$150
D3330	Root canal - molar per tooth	\$150	\$200	\$235	\$260	\$285
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$50	\$75	\$100	\$125	\$150

Code	Description	Copayments				
D3346	Retreatment of previous root canal therapy - anterior	\$70	\$95	\$120	\$225	\$250
D3347	Retreatment of previous root canal therapy - bicuspid	\$100	\$120	\$145	\$275	\$300
D3348	Retreatment of previous root canal therapy - molar	\$190	\$210	\$235	\$300	\$375
D3351	Apexification/recalcification - initial visit	\$55	\$75	\$85	\$105	\$135
D3352	Apexification/recalcification - interim medication replacement	\$45	\$65	\$75	\$95	\$125
D3353	Apexification/recalcification - final visit (includes completed root canal)	\$55	\$75	\$85	\$105	\$135
D3410	Apicoectomy/periradicular surgery - anterior	\$150	\$200	\$225	\$250	\$275
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$150	\$200	\$225	\$250	\$275
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$200	\$200	\$225	\$250	\$275
D3426	Apicoectomy/periradicular surgery (each additional root)	\$100	\$100	\$100	\$125	\$125
D3430	Retrograde filling - per root	\$100	\$150	\$150	\$150	\$150
D3450	Root amputation - per root	\$75	\$100	\$100	\$150	\$200
D3920	Hemisection (including any root removal), not including root canal therapy	\$100	\$115	\$115	\$125	\$150

Periodontics

* - Covered only when preformed by the member's primary general dentist

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth per quadrant	\$40	\$50	\$100	\$125	\$175
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth per quadrant	\$35	\$40	\$65	\$70	\$75
D4240	Gingival flap procedure - 4 or more contiguous teeth per quadrant	\$275	\$300	\$325	\$350	\$400
D4241	Gingival flap procedure - 1 to 3 contiguous teeth per quadrant	\$195	\$225	\$250	\$250	\$250
D4249	Clinical crown lengthening - hard tissue*	\$100	\$125	\$135	\$150	\$175
D4260	Osseous surgery - 4 or more contiguous teeth per quadrant	\$250	\$300	\$325	\$350	\$400
D4261	Osseous surgery - 1 to 3 contiguous teeth per quadrant	\$200	\$225	\$250	\$275	\$300
D4263	Bone replacement graft - first site in quadrant	\$200	\$225	\$250	\$300	\$350
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$20	\$25	\$35	\$50	\$65
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$20	\$20	\$30	\$40	\$50
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$20	\$25	\$25	\$25	\$25
D4381	Localized delivery of antimicrobial agents, per tooth	\$60	\$60	\$60	\$60	\$60
D4910	Periodontal maintenance - once every 6 months	\$25	\$25	\$30	\$40	\$50
D4910	Periodontal maintenance - each additiional	\$50	\$50	\$50	\$50	\$50

Removable Prosthodontics

Replaced once every 5 years & relined once every 24 months

D5110	Complete upper denture	\$90	\$125	\$175	\$300	\$350
D5120	Complete lower denture	\$90	\$125	\$175	\$300	\$350
D5130	Immediate upper denture	\$90	\$125	\$175	\$300	\$350
D5140	Immediate lower denture	\$90	\$125	\$175	\$300	\$350
D5211	Upper partial denture - resin base	\$125	\$150	\$225	\$250	\$300
D5212	Lower partial denture - resin base	\$125	\$150	\$225	\$250	\$300
D5213	Upper partial denture - cast metal framework with resin denture bases	\$125	\$150	\$225	\$300	\$400
D5214	Lower partial denture - cast metal framework with resin denture bases	\$125	\$150	\$225	\$300	\$400

Code	Description	Copayments				
D5225	Upper partial denture - flexible base	\$125	\$150	\$225	\$350	\$450
D5226	Lower partial denture - flexible base	\$125	\$150	\$225	\$350	\$450
D5410	Adjust complete denture - upper	\$0	\$0	\$0	\$15	\$25
D5411	Adjust complete denture - lower	\$0	\$0	\$0	\$15	\$25
D5421	Adjust partial denture - upper	\$0	\$0	\$0	\$10	\$20
D5422	Adjust partial denture - lower	\$0	\$0	\$0	\$10	\$20
D5510	Repair broken complete denture base	\$10	\$15	\$15	\$40	\$50
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$10	\$15	\$15	\$20	\$25
D5610	Repair resin denture base	\$10	\$15	\$15	\$40	\$50
D5620	Repair cast framework	\$10	\$15	\$15	\$40	\$50
D5630	Repair or replace broken clasp	\$10	\$15	\$15	\$35	\$40
D5640	Replace broken teeth - per tooth	\$10	\$15	\$15	\$20	\$25
D5650	Add tooth to existing partial denture	\$10	\$15	\$15	\$30	\$50
D5660	Add clasp to existing partial denture	\$10	\$15	\$15	\$30	\$50
D5670	Replace all teeth and acrylic on cast metal framework (Upper)	\$100	\$100	\$165	\$265	\$350
D5671	Replace all teeth and acrylic on cast metal framework (Lower)	\$100	\$100	\$165	\$265	\$350
D5710	Rebase complete upper denture	\$40	\$50	\$50	\$75	\$95
D5711	Rebase complete lower denture	\$40	\$50	\$50	\$75	\$95
D5720	Rebase upper partial denture	\$40	\$50	\$50	\$75	\$95
D5721	Rebase lower partial denture	\$40	\$50	\$50	\$75	\$95
D5730	Reline complete upper denture (chairside)	\$25	\$40	\$40	\$50	\$65
D5731	Reline complete lower denture (chairside)	\$25	\$40	\$40	\$50	\$65
D5740	Reline upper partial denture (chairside)	\$25	\$40	\$40	\$50	\$65
D5741	Reline lower partial denture (chairside)	\$25	\$40	\$40	\$50	\$65
D5750	Reline complete upper denture (laboratory)	\$25	\$40	\$40	\$85	\$100
D5751	Reline complete lower denture (laboratory)	\$25	\$40	\$40	\$85	\$100
D5760	Reline upper partial denture (laboratory)	\$25	\$40	\$40	\$85	\$100
D5761	Reline lower partial denture (laboratory)	\$25	\$40	\$40	\$85	\$100
D5820	Interim partial denture (upper)	\$40	\$40	\$40	\$105	\$150
D5821	Interim partial denture (lower)	\$40	\$40	\$40	\$105	\$150
D5850	Tissue conditioning, upper	\$10	\$10	\$10	\$25	\$25
D5851	Tissue conditioning, lower	\$10	\$10	\$10	\$25	\$25

Code	Description	Copayments				
<u>Alternative Dentures, Bridges & Relines</u>						
Most dental offices offer alternative to complete and partial dentures and relines which are marketed under different brand names and maybe available through your California Dental participating provider for the following copayments:						
Complete Denture						
	Comfort Flex - Complete Upper Denture	\$550	\$550	\$600	\$650	\$700
	Comfort Flex - Complete Lower Denture	\$550	\$550	\$600	\$650	\$700
	Geneva - Complete Upper Denture	\$550	\$550	\$600	\$650	\$700
	Geneva - Complete Lower Denture	\$550	\$550	\$600	\$650	\$700
Simply Natural						
Partial Denture - Resin Base						
	Comfort Flex - Upper Partial	\$600	\$600	\$650	\$700	\$750
	Comfort Flex - Lower Partial	\$600	\$600	\$650	\$700	\$750
	Geneva - Upper Partial	\$600	\$600	\$650	\$700	\$750
	Geneva - Lower Partial	\$600	\$600	\$650	\$700	\$750
	EstheticClasp - Upper Partial	\$600	\$600	\$650	\$700	\$750
	EstheticClasp - Lower Partial	\$600	\$600	\$650	\$700	\$750
	CuSil - Upper Partial	\$600	\$600	\$650	\$700	\$750
	CuSil - Lower Partial	\$600	\$600	\$650	\$700	\$750
	Valplast - Upper Partial	\$600	\$600	\$650	\$700	\$750
	Valplast - Lower Partial	\$600	\$600	\$650	\$700	\$750
Partial Denture - Cast Metal Base with Resin Saddles						
	Comfort Flex - Upper Partial	\$600	\$600	\$650	\$700	\$750
	Comfort Flex - Lower Partial	\$600	\$600	\$650	\$700	\$750
	Valplast - Upper Partial	\$600	\$600	\$650	\$700	\$750
	Valplast - Lower Partial	\$600	\$600	\$650	\$700	\$750
Denture Relines						
	PermaSoft - Complete Upper Denture (Laboratory)	\$100	\$100	\$100	\$100	\$100
	PermaSoft - Complete Lower Denture (Laboratory)	\$100	\$100	\$100	\$100	\$100
	PermaSoft - Partial Upper Denture (Laboratory)	\$100	\$100	\$100	\$100	\$100
	PermaSoft - Partial Lower Denture (Laboratory)	\$100	\$100	\$100	\$100	\$100
D5900 - D5999 VII Maxillofacial Prosthetics - Not Covered						
D6000 - D6199 VIII Implant Services - Not Covered						

Code	Description	Copayments				
Fixed Prosthodontics						
D6210	Pontic - cast high noble metal	\$225	\$250	\$300	\$350	\$400
D6211	Pontic - cast predominantly base metal	\$75	\$100	\$150	\$200	\$250
D6212	Pontic - cast noble metal	\$175	\$200	\$250	\$300	\$350
D6214	Pontic - titanium	\$225	\$250	\$300	\$350	\$400
D6240	Pontic - porcelain fused to high noble metal	\$225	\$250	\$300	\$350	\$400
D6241	Pontic - porcelain fused to predominantly base metal	\$75	\$100	\$150	\$200	\$250
D6242	Pontic - porcelain fused to noble metal	\$175	\$200	\$250	\$300	\$350
D6600	Inlay - porcelain/ceramic, 2 surfaces	\$195	\$200	\$225	\$265	\$300
D6601	Inlay - porcelain/ceramic, 3 or more surfaces	\$210	\$215	\$240	\$295	\$350
D6602	Inlay - cast high noble metal, 2 surfaces	\$225	\$250	\$300	\$350	\$400
D6603	Inlay - cast high noble metal, 3 or more surfaces	\$275	\$300	\$350	\$400	\$450
D6604	Inlay - cast predominantly base metal, 2 surfaces	\$125	\$150	\$200	\$250	\$300
D6605	Inlay - cast predominantly base metal, 3 or more surfaces	\$175	\$200	\$250	\$300	\$350
D6606	Inlay - cast noble metal, 2 surfaces	\$175	\$200	\$250	\$300	\$350
D6607	Inlay - cast noble metal, 3 or more surface	\$225	\$250	\$300	\$350	\$400
D6608	Onlay -porcelain/ceramic, 2 surfaces	\$195	\$200	\$225	\$265	\$300
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	\$210	\$215	\$240	\$265	\$300
D6610	Onlay - cast high noble metal, 2 surfaces	\$225	\$250	\$300	\$350	\$400
D6611	Onlay - cast high noble metal, 3 or more surfaces	\$275	\$300	\$350	\$400	\$450
D6612	Onlay - cast predominantly base metal, 2 surfaces	\$125	\$150	\$200	\$250	\$300
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	\$175	\$200	\$250	\$300	\$350
D6614	Onlay - cast noble metal, 2 surfaces	\$175	\$200	\$250	\$300	\$350
D6615	Onlay - cast noble metal, 3 or more surfaces	\$225	\$250	\$300	\$350	\$400
D6624	Inlay - titanium	\$225	\$250	\$300	\$350	\$400
D6634	Onlay - titanium	\$225	\$250	\$300	\$350	\$400
D6750	Crown - porcelain fused to high noble metal	\$225	\$250	\$300	\$350	\$400
D6751	Crown - porcelain fused to predominantly base metal	\$75	\$100	\$150	\$200	\$250
D6752	Crown - porcelain fused to noble metal	\$175	\$200	\$250	\$300	\$350
D6780	Crown - 3/4 cast high noble metal	\$225	\$250	\$300	\$350	\$400
D6781	Crown - 3/4 cast predominantly base metal	\$75	\$100	\$150	\$200	\$250
D6782	Crown - 3/4 cast noble metal	\$175	\$200	\$250	\$300	\$350
D6783	Crown - 3/4 porcelain/ceramic	\$225	\$250	\$300	\$350	\$400
D6790	Crown - full cast high noble metal	\$225	\$250	\$300	\$350	\$400
D6791	Crown - full cast predominantly base metal	\$75	\$100	\$150	\$200	\$250
D6792	Crown - full cast noble metal	\$175	\$200	\$250	\$300	\$350
D6794	Crown - titanium	\$225	\$250	\$300	\$350	\$400
D6930	Recement fixed partial denture	\$0	\$0	\$0	\$25	\$25
D6970	Cast post and core in addition to fixed partial denture retainer	\$30	\$40	\$50	\$65	\$75
D6971	Cast post as part of fixed partial denture retainer	\$30	\$40	\$50	\$65	\$75
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$30	\$40	\$50	\$60	\$70

Code	Description	Copayments				
D6973	Core build up for retainer, including any pins	\$0	\$10	\$15	\$20	\$25
D6976	Each additional cast post - same tooth	\$0	\$40	\$40	\$50	\$50
D6977	Each additional prefabricated post - same tooth	\$0	\$40	\$40	\$50	\$50
D6980	Fixed partial denture repair, by report	\$50	\$50	\$75	\$100	\$100
<u>Oral Surgery</u>						
D7111	Extraction, coronal remnants - deciduous tooth	\$0	\$0	\$0	\$10	\$25
D7140	Extraction, erupted tooth or exposed root	\$0	\$0	\$0	\$10	\$25
D7210	Surgical removal of erupted tooth	\$0	\$20	\$30	\$35	\$45
D7220	Removal of impacted tooth - soft tissue	\$0	\$50	\$60	\$75	\$90
D7230	Removal of impacted tooth - partially bony	\$0	\$100	\$125	\$150	\$175
D7240	Removal of impacted tooth - completely bony	\$0	\$125	\$150	\$175	\$200
D7241	Removal of impacted tooth - completely bony, with unusual complications	\$0	\$130	\$155	\$180	\$210
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$0	\$50	\$60	\$80	\$90
D7270	Tooth reimplantation and/or stabilization of accidentally displaced tooth	\$100	\$110	\$130	\$150	\$200
D7310	Alveoloplasty in conjunction with extractions - per quadrant	\$0	\$0	\$10	\$50	\$70
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	\$0	\$0	\$10	\$50	\$70
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	\$0	\$0	\$10	\$70	\$90
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth/spaces per quadrant	\$0	\$0	\$10	\$70	\$90
D7510	Incision and drainage of abscess - intraoral soft tissue	\$0	\$40	\$60	\$75	\$100
<u>Orthodontics</u>						
* - Covered for up to 24 months of active treatment						
D8020	Limited orthodontic treatment of the transitional dentition*	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
D8030	Limited orthodontic treatment of the adolescent dentition*	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
D8040	Limited orthodontic treatment of the adult dentition*	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
D8050	Interceptive orthodontic treatment of the primary dentition*	\$1,150	\$1,150	\$1,150	\$1,150	\$1,150
D8060	Interceptive orthodontic treatment of the transitional dentition*	\$1,150	\$1,150	\$1,150	\$1,150	\$1,150
D8070	Comprehensive orthodontic treatment of the transitional dentition*	\$1,775	\$1,775	\$1,775	\$1,845	\$1,845
D8080	Comprehensive orthodontic treatment of the adolescent dentition*	\$1,775	\$1,775	\$1,775	\$1,845	\$1,845
D8090	Comprehensive orthodontic treatment of the adult dentition*	\$1,975	\$1,975	\$1,975	\$2,045	\$2,045
D8660	Pre-orthodontic treatment visit	\$0	\$0	\$0	\$0	\$0
D8680	Orthodontic retention - Per Arch	\$125	\$125	\$125	\$125	\$125
D8999	Orthodontic Treatment Plan and Records(pre/post x-rays, photos, study models)	\$250	\$250	\$250	\$250	\$250
D8999	Active Orthodontic Treatment beyond 24 months - Per Visit	\$75	\$75	\$75	\$75	\$75

Code	Description	Copayments				
Adjunctive General Services						
* - Covered only for the removal of impacted wisdom teeth (1,16,17 & 32)						
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$0	\$0	\$0	\$0	\$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0	\$0	\$0	\$0	\$0
D9215	Local anesthesia	\$0	\$0	\$0	\$0	\$0
D9220	Deep sedation/general anesthesia - first 30 minutes*	\$175	\$175	\$200	\$200	\$200
D9221	Deep sedation/general anesthesia - each additional 15 minutes*	\$85	\$85	\$100	\$100	\$100
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide*	\$15	\$15	\$15	\$15	\$15
D9241	Intravenous conscious sedation/analgesia - first 30 minutes*	\$150	\$150	\$175	\$175	\$175
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes*	\$65	\$65	\$80	\$80	\$80
D9310	Consultation & Second Opinion, with prior authorization from Plan	\$25	\$25	\$25	\$25	\$25
D9430	Office visit for observation (during regularly scheduled hours)	\$0	\$0	\$0	\$0	\$0
D9440	Office visit - after regularly scheduled hours	\$25	\$30	\$35	\$35	\$35
D9999	Office visit - during regular office hours in addition to other charges	\$0	\$0	\$0	\$5	\$5
D9630	Other drugs and/or medicaments, (including antimicrobial irrigation)	\$15	\$20	\$25	\$40	\$40
D9910	Application of desensitizing medicament	\$15	\$15	\$15	\$15	\$15
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	\$15	\$15	\$15	\$15	\$15
D9940	Occlusal guard - Soft	\$150	\$150	\$150	\$150	\$150
D9942	Repair/reline occlusal guard	\$40	\$40	\$40	\$40	\$40
D9951	Occlusal adjustment - limited	\$15	\$15	\$15	\$20	\$20
D9972	External bleaching - per arch	\$125	\$125	\$125	\$125	\$125
D9973	External bleaching - per tooth	\$20	\$25	\$30	\$30	\$30
D9999	Broken Appopintment - less than 24 notice	\$25	\$25	\$25	\$25	\$25



California Dental Network, Inc is licensed by the California Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act (License number 933-0286).

Oct-06



**Provider Application
Individual Dentist Information**

(Must be completed for each dentist who will treat CDN Members)

Dentist:

Full Name _____
(Please Print)

Degree(s) _____

Social Security Number _____ - _____ - _____

Date of Birth _____ - _____ - _____

CA Dental License #'s _____

DEA Number _____

Education/Training:

Undergraduate School _____ Degree _____ Year Graduated _____

Post Graduate School _____ Degree _____ Year Graduated _____

Dental School _____ Degree _____ Year Graduated _____

Residency _____
Facility _____ Location _____

Specialty Field _____ Dates _____

Other Training Programs _____
Facility _____ Location _____

Specialty Field _____ Dates _____

Professional Associations:

Membership in dental societies and associations: _____

Positions of responsibility in local, state or national dental associations: _____

Dental school or other teaching appointments: _____

Scope of Practice:

(General Dentists Only)

Please check the service that you routinely perform for your patient.

- Periodontics
- ___ Scaling/Root Planning
- ___ Soft tissue management
- ___ Surgery

- Endodontics
- ___ Anterior root canals
- ___ Bicuspid root canals
- ___ First molars
- ___ Second molars
- ___ Apical surgery

- Oral Surgery
- Surgical removal of:
- ___ Erupted tooth
- ___ Soft tissue impactions
- ___ Partial bony impactions
- ___ Full bony impactions

(Over)

Liability Coverage:

Liability Carrier _____

Policy Number _____ Expiration Date _____

Amount of Coverage Per Occurrence _____ Aggregate _____

Do you have any pending malpractice cases/claims against you? Yes ___ No ___

Number of prior malpractice settlements/judgments _____

For each malpractice action, please attach an explanation, which includes the facts of each action and the amount of settlement.

Licensure:

Have you ever:

Had your license, in any state, suspended, revoked, restricted or limited? Yes ___ No ___

Been conviction, or pleaded guilty to a felony, moral or ethical crime? Yes ___ No ___

Had any chronic illnesses, physical defects or addiction, that would impair your ability to practice dentistry? Yes ___ No ___

Had your membership denied, not renewed, or been subject to disciplinary proceedings in any dental organization? Yes ___ No ___

Been licensed to practice dentistry in another state, or under another name? Yes ___ No ___

Please attach an explanation for any questions answered "Yes".

Certification & Release of information:

The undersigned hereby certifies that the above information is true, correct and complete to the best of my knowledge, and that the intentional submission of false or misleading information or withholding of relevant information is grounds for denial or termination as a participating provider with California Dental Network, Inc., or any of its affiliated organizations. The undersigned hereby authorizes California Dental Network, Inc., to consult individuals, groups and/or organizations having information concerning my education, training, qualifications or experience, including malpractice claims history, and to inspect all pertinent documentation. The undersigned hereby releases California Dental Network, Inc., and its representatives and affiliates from any liability for their acts performed in good faith and without malice in evaluating my credentials and qualifications including any malpractice liability claims information, and do hereby further release all individuals and organizations which provide information to California Dental Network, Inc. regarding my professional competence, ethics, character and other qualifications or affiliations, including malpractice claims information, from any liability provided they are acting in good faith and without malice. The undersigned hereby agrees to notify California Dental Network, Inc. in a timely manor of any changes in the above information.

NAME: _____
(Please Print or Type)

Signature: _____ Date: _____

**Provider Application
Dental Facility Information**
(Use a separate form for each Location)

Dental Facility:

Name of Practice _____
(As you want it to appear in our provider directory)

Street Address _____

City _____ County _____ State _____ Zip Code _____

Mailing Address, If Different _____

City _____ County _____ State _____ Zip Code _____

Office Numbers:
Phone (_____) _____ - _____ Fax (_____) _____ - _____

Legal Entity: Corporation _____ Partnership _____ Sole Proprietor _____ Tax I.D. Number _____

Principal Owner(s):	Dental License #
_____	_____
_____	_____

Principal Contacts:

Dentist _____ Phone (_____) _____ - _____ Ext. _____

Administrator _____ Phone (_____) _____ - _____ Ext. _____

Staffing:

Office Staff (FTE's):
Dentists _____ Hygienists _____ RDA's/DA's _____ Admin Staff _____

Associate Dentist(s) Name	Dental License #	Specialty	Hours/Week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Complete an "Individual Dentist Information" form for each Owner and Associate)

Availability/Capacity:

Office Hours:
Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____ Sat: _____ Sun: _____

of Operatories: _____ Patient Base: _____ FFS/Indemnity _____ % Prepaid _____ % Denti-Cal _____ %

Other Managed Care Plans Accepted: _____

Appointment availability: New Patient _____ Routine _____ Hygiene _____ Emergency _____

Foreign Languages Spoken: _____

Accessibility:

Location:

Ground Floor: _____ 2nd or Higher: _____ Elevator: Yes ___ No ___ N/A ___

Free Parking: Yes ___ No ___ # of Parking Spaces: _____ On site restrooms: Yes ___ No ___

Handicap accessible:

Parking: Yes ___ No ___ Restrooms: Yes ___ No ___ Front Door: Yes ___ No ___
Elevator: Yes ___ No ___ Operatories: Yes ___ No ___ X-Rays: Yes ___ No ___

Routine appointment intervals: _____ Average waiting time in office with appointment: _____

Appointments per dentist/day: _____ Describe broken appointment policy & follow up system:

Are emergency services available 24 hours a day: Yes ___ No ___

Describe how you provide for emergency services in your absence: _____

Specialists to whom your Practice refers patients:

Endodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Periodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Oral Surgeon: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Pedodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Please print or type	Name (See Specific Instructions on page 2.)	
	Business name, if different from above. (See Specific Instructions on page 2.)	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		

Part I Taxpayer Identification Number (TIN)	List account number(s) here (optional)				
<p>Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.</p> <p>Note: <i>If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.</i></p>	Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)				
<table style="margin: auto;"> <tr> <td style="border: 1px solid black; padding: 2px;">Social security number</td> </tr> <tr> <td style="text-align: center;"> + </td> </tr> <tr> <td style="text-align: center;">or</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Employer identification number</td> </tr> <tr> <td style="text-align: center;"> + </td> </tr> </table>		Social security number	+	or	Employer identification number
Social security number					
+					
or					
Employer identification number					
+					

Part III Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **and**
- I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.**

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

- You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all

such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to

report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.



