2023 Dental Standard Benefit Plan Design

<table>
<tr><td colspan="2" rowspan="4">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.</td><td colspan="2">Family Dental Plan</td></tr>
<tr><td colspan="2">Copay Plan</td></tr>
<tr><td>Pediatric Dental EHB</td><td>Adult Dental</td></tr>
<tr><td>Up to Age 19</td><td>Age 19 and Older</td></tr>
<tr><td colspan="2">Actuarial Value</td><td>84.33%</td><td>Not Calculated</td></tr>
<tr><td colspan="2"></td><td>In-Network</td><td>In-Network</td></tr>
<tr><td colspan="2">Individual Deductible</td><td>None</td><td>None</td></tr>
<tr><td colspan="2">Family Deductible (Two or more children)</td><td>Not Applicable</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Individual Out of Pocket Maximum</td><td>$350</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Family Out of Pocket Maximum (Two or More Children)</td><td>$700</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Office Copay</td><td>$0</td><td>$0</td></tr>
<tr><td colspan="2">Waiting Period
(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d).)</td><td>None</td><td>None</td></tr>
<tr><td colspan="2">Annual Benefit Limit
(the maximum amount the dental plan will pay in the benefit year)</td><td>None</td><td>None</td></tr>
<tr><td>Procedure Category</td><td>Service Type</td><td>Member Cost Share</td><td>Member Cost Share</td></tr>
<tr><td rowspan="6">Diagnostic & Preventive</td><td>Oral Exam</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Preventive - Cleaning</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Preventive - X-ray</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Sealants per Tooth</td><td>No charge</td><td>No charge if covered</td></tr>
<tr><td>Topical Fluoride Application</td><td>No charge</td><td>No charge if covered</td></tr>
<tr><td>Space Maintainers - Fixed</td><td>No charge</td><td>No charge if covered</td></tr>
<tr><td rowspan="4">Basic Services</td><td>Restorative Procedures</td><td rowspan="4">See 2023 Dental Copay Schedule</td><td rowspan="4">See 2023 Dental Copay Schedule</td></tr>
<tr><td>Periodontal Maintenance Services</td></tr>
<tr><td>Adult Periodontics (other than maintenance)
(Group Dental Plans only)</td></tr>
<tr><td>Adult Endodontics
(Group Dental Plans only)</td></tr>
<tr><td rowspan="5">Major Services</td><td>Periodontics (other than maintenance)</td><td rowspan="5">See 2023 Dental Copay Schedule</td><td rowspan="5">See 2023 Dental Copay Schedule</td></tr>
<tr><td>Endodontics</td></tr>
<tr><td>Crowns and Casts</td></tr>
<tr><td>Prosthodontics</td></tr>
<tr><td>Oral Surgery</td></tr>
<tr><td>Orthodontia</td><td>Medically Necessary Orthodontia</td><td>$350</td><td>Not covered</td></tr>
</table>

SCHEDULE A
Description of Benefits and Copayments
[Delta Dental Individual & Family
DeltaCare® USA
Family Dental HMO]

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their assigned Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Under Age 19):

Pediatric Enrollee …………………………….	$350.00 each Calendar Year
Multiple Pediatric Enrollees ……………	$700.00 each Calendar Year

OOPM applies only to Essential Health Benefits ("EHB") for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Pediatric Benefits under this Plan during a Calendar Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments, or that are not covered under this Policy, will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered by this Policy, the financial obligation for Pediatric Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets their OOPM, they will have no further payment for the remainder of the Calendar Year for Pediatric Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for Pediatric Benefits.

Delta Dental recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact Delta Dental's Customer Care at 888-282-8528.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	No charge	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	No charge	*1 per 6 months per Contract Dentist*	
D0140	Limited oral evaluation - problem focused	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	Not Covered	*1 per 6 months per Contract Dentist, included with D0120, D0150*	
D0150	Comprehensive oral evaluation - new or established patient	No charge	No charge	*Initial evaluation, 1 per Contract Dentist*	
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	No charge	*6 per 3 months, not to exceed 12 per 12 month period*	
D0171	Re-evaluation - post-operative office visit	No charge	No charge		
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	No charge	*Included with D0150*	
D0190	Screening of a patient	Not Covered	No charge		
D0191	Assessment of a patient	Not Covered	No charge		
D0210	Intraoral - complete series of radiographic images	No charge	No charge	*1 series per 36 months per Contract Dentist*	*1 series per 24 months*
D0220	Intraoral - periapical first radiographic image	No charge	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*	
D0230	Intraoral - periapical each additional radiographic image	No charge	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*	
D0240	Intraoral - occlusal radiographic image	No charge	No charge	*2 per 6 months per Contract Dentist*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	No charge	*1 per date of service*	
D0251	Extra-oral posterior dental radiographic image	No charge	Not Covered	*4 per date of service*	
D0270	Bitewing - single radiographic image	No charge	No charge	*1 of (D0270, D0273) per date of service*	
D0272	Bitewings - two radiographic images	No charge	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*	
D0273	Bitewings - three radiographic images	No charge	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*	
D0274	Bitewings - four radiographic images	No charge	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*	
D0310	Sialography	No charge	Not Covered		
D0320	Temporomandibular joint arthrogram, including injection	No charge	Not Covered	*Limited to trauma or pathology; 3 per date of service*	
D0322	Tomographic survey	No charge	Not Covered	*2 per 12 months per Contract Dentist*	
D0330	Panoramic radiographic image	No charge	No charge	*1 per 36 months per Contract Dentist*	*1 per 24 consecutive months*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	Not Covered	*2 per 12 months per Contract Dentist*	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	Not Covered	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*	
D0351	3D photographic image	No charge	No charge	*1 per date of service*	
D0419	Assessment of salivary flow by measurement	Not Covered	No charge		*1 per 12 months*
D0460	Pulp vitality tests	No charge	No charge		
D0470	Diagnostic casts	No charge	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*	
D0502	Other oral pathology procedures, by report	No charge	Not Covered	*Performed by an oral pathologist*	
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	No charge		
D0702	2D cephalometric radiographic image - image capture only	No charge	No charge		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	No charge		
D0704	3D photographic image - image capture only	No charge	No charge		
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	Not Covered		
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	No charge		
D0707	Intraoral - periapical radiographic image - image capture only	No charge	No charge		
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	No charge		
D0709	Intraoral - complete series of radiographic images - image capture only	No charge	No charge		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	No charge	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1120	Prophylaxis - child	No charge	Not Covered	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	
D1206	Topical application of fluoride varnish	No charge	No charge	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride - excluding varnish	No charge	No charge	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	No charge	No charge		
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	No charge		
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	Not Covered		
D1330	Oral hygiene instructions	No charge	No charge		
D1351	Sealant - per tooth	No charge	Not Covered	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	Not Covered	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*	
D1353	Sealant repair - per tooth	No charge	Not Covered	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*	
D1354	Interim caries arresting medicament application - per tooth	No charge	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	Not Covered	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*	
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant; posterior teeth*	
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	Not Covered	*1 per arch; posterior teeth*	
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	Not Covered	*1 per arch; posterior teeth*	
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant; posterior teeth*	
D1526	Space maintainer - removable - bilateral, maxillary	No charge	Not Covered	*1 per arch, through age 17; posterior teeth*	
D1527	Space maintainer - removable - bilateral, mandibular	No charge	Not Covered	*1 per arch, through age 17; posterior teeth*	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant, age 8 and under; posterior teeth*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.					

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2140	Amalgam - one surface, primary or permanent	$25	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2150	Amalgam - two surfaces, primary or permanent	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2160	Amalgam - three surfaces, primary or permanent	$40	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2161	Amalgam - four or more surfaces, primary or permanent	$45	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2330	Resin-based composite - one surface, anterior	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2331	Resin-based composite - two surfaces, anterior	$45	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2332	Resin-based composite - three surfaces, anterior	$55	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2390	Resin-based composite crown, anterior	$50	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2391	Resin-based composite - one surface, posterior	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2392	Resin-based composite - two surfaces, posterior	$40	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2393	Resin-based composite - three surfaces, posterior	$50	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2394	Resin-based composite - four or more surfaces, posterior	$70	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2542	Onlay - metallic - two surfaces	Not Covered	$185		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2543	Onlay - metallic - three surfaces	Not Covered	$200		*1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not Covered	$215		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	$250		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	$275		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	$300		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$160		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$180		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$200		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	$140	$140	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	$200	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2720	Crown - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2722	Crown - resin with noble metal	Not Covered	$300		*1 per 60 months*
D2740	Crown - porcelain/ceramic substrate	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not Covered	$300		*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not Covered	$300		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$310	$310	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2790	Crown - full cast high noble metal	Not Covered	$300		*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2792	Crown - full cast noble metal	Not Covered	$300		*1 per 60 months*
D2794	Crown - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	$25	*1 per 12 months per Contract Dentist*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	$25		
D2920	Re-cement or re-bond crown	$25	$15	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	$45	*1 per 12 months*	*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	Not Covered	*1 per 36 months*	
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not Covered	*1 per 12 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$65	Not Covered	*1 per 12 months*	
D2931	Prefabricated stainless steel crown - permanent tooth	$75	$75	*1 per 36 months*	
D2932	Prefabricated resin crown	$75	Not Covered	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*	
D2933	Prefabricated stainless steel crown with resin window	$80	Not Covered	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*	
D2940	Protective restoration	$25	$20	*1 per 6 months per Contract Dentist*	
D2941	Interim therapeutic restoration - primary dentition	$30	Not Covered	*1 per tooth per 6 months per Contract Dentist*	
D2949	Restorative foundation for an indirect restoration	$45	Not Covered		
D2950	Core buildup, including any pins when required	$20	$20		
D2951	Pin retention - per tooth, in addition to restoration	$25	$20	*1 per tooth regardless of the number of pins placed; permanent teeth*	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	$30	$30	*Performed in conjunction with D2952*	
D2954	Prefabricated post and core in addition to crown	$90	$60	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Includes canal preparation*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2955	Post removal	$60	Not Covered	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2957	Each additional prefabricated post - same tooth	$35	$35	*Performed in conjunction with D2954*	
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	Not Covered	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*	
D2980	Crown repair necessitated by restorative material failure	$50	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*	
D2999	Unspecified restorative procedure, by report	$40	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	$20	$20		
D3120	Pulp cap - indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	Not Covered	*1 per primary tooth*	
D3221	Pulpal debridement, primary and permanent teeth	$40	$50	*1 per tooth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	Not Covered	*1 per permanent tooth*	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	Not Covered	*1 per tooth*	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	Not Covered	*1 per tooth*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	$200	*Root canal*	*Root canal*
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	$235	*Root canal*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	$300	*Root canal*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	$85		
D3333	Internal root repair of perforation defects	$80	$80		
D3346	Retreatment of previous root canal therapy - anterior	$240	$245	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3347	Retreatment of previous root canal therapy - bicuspid	$295	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3348	Retreatment of previous root canal therapy - molar	$365	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	Not Covered	*1 per permanent tooth*	
D3352	Apexification/recalcification - interim medication replacement	$45	Not Covered	*1 per permanent tooth*	
D3410	Apicoectomy - anterior	$240	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3421	Apicoectomy - bicuspid (first root)	$250	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3425	Apicoectomy - molar (first root)	$275	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3426	Apicoectomy (each additional root)	$110	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*	
D3430	Retrograde filling - per root	$90	$90		
D3450	Root amputation - per root	Not Covered	$110		
D3471	Surgical repair of root resorption - anterior	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3472	Surgical repair of root resorption - premolar	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3473	Surgical repair of root resorption - molar	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	Not Covered		
D3920	Hemisection (including any root removal), not including root canal therapy	Not Covered	$120		
D3999	Unspecified endodontic procedure, by report	$100	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	$150	*1 per quadrant per 36 months, age 13+*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50	*1 per quadrant per 36 months, age 13+*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not Covered	$135		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not Covered	$70		
D4249	Clinical crown lengthening - hard tissue	$165	$200		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	$265	*1 per quadrant per 36 months, age 13+*	
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	$140	*1 per quadrant per 36 months, age 13+*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	Not Covered	$105		
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not Covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	Not Covered		
D4266	Guided tissue regeneration - resorbable barrier, per site	Not Covered	$145		
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not Covered	$175		
D4270	Pedicle soft tissue graft procedure	Not Covered	$155		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered	$220		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not Covered	$190		*1 per quadrant per 36 months*
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$185		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	$55	*1 per quadrant per 24 months; age 13+*	*4 quadrants per 12 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	$25	*1 per quadrant per 24 months; age 13+*	*4 quadrants per 12 consecutive months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40	$40	*1 treatment per 12 consecutive months*	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	$10		
D4910	Periodontal maintenance	$30	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*	*2 treatments per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	Not Covered	*1 per Contract Dentist; age 13+*	
D4999	Unspecified periodontal procedure, by report	$350	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.					
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.					
D5110	Complete denture - maxillary	$300	$400	*1 per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$300	$400	*1 per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	*1 per 60 months*
D5140	Immediate denture - mandibular	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	$325	*1 per 60 months*	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	$325	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	$375	*1 per 60 months*	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	$375	*1 per 60 months*	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	$300	*1 per 60 months*	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	$300	*1 per 60 months*	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	$370	*1 per 60 months*	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	$370	*1 per 60 months*	*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	$375		*1 per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	$375		*1 per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375		*1 per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375		*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not Covered	$250		*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not Covered	$250		*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$250		*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$250		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5410	Adjust complete denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5411	Adjust complete denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5421	Adjust partial denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5422	Adjust partial denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5511	Repair broken complete denture base, mandibular	$40	$30	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5512	Repair broken complete denture base, maxillary	$40	$30	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	$30	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*	
D5611	Repair resin denture base, mandibular	$40	$30	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5612	Repair resin denture base, maxillary	$40	$30	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5621	Repair cast framework, mandibular	$40	$35	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5622	Repair cast framework, maxillary	$40	$35	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5630	Repair or replace broken retentive clasping materials - per tooth	$50	$30	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5640	Replace broken teeth - per tooth	$35	$30	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5650	Add tooth to existing partial denture	$35	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5660	Add clasp to existing partial denture - per tooth	$60	$45	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	$195		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	$195		
D5710	Rebase complete maxillary denture	Not Covered	$155		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not Covered	$155		*1 per 12 months*
D5720	Rebase maxillary partial denture	Not Covered	$150		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not Covered	$150		*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$60	$80	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$60	$80	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5850	Tissue conditioning, maxillary	$30	$35	*2 per prosthesis per 36 months after the initial 6 months*	*1 per 12 months*
D5851	Tissue conditioning, mandibular	$30	$35	*2 per prosthesis per 36 months after the initial 6 months*	*1 per 12 months*
D5862	Precision attachment, by report	$90	Not Covered	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*	
D5863	Overdenture - complete maxillary	$300	Not Covered	*1 per 60 months*	
D5864	Overdenture - partial maxillary	$300	Not Covered	*1 per 60 months*	
D5865	Overdenture - complete mandibular	$300	Not Covered	*1 per 60 months*	
D5866	Overdenture - partial mandibular	$300	Not Covered	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5899	Unspecified removable prosthodontic procedure, by report	$350	$400	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS					
- All maxillofacial prosthetic procedures require prior Authorization.					
D5911	Facial moulage (sectional)	$285	Not Covered		
D5912	Facial moulage (complete)	$350	Not Covered		
D5913	Nasal prosthesis	$350	Not Covered		
D5914	Auricular prosthesis	$350	Not Covered		
D5915	Orbital prosthesis	$350	Not Covered		
D5916	Ocular prosthesis	$350	Not Covered		
D5919	Facial prosthesis	$350	Not Covered		
D5922	Nasal septal prosthesis	$350	Not Covered		
D5923	Ocular prosthesis, interim	$350	Not Covered		
D5924	Cranial prosthesis	$350	Not Covered		
D5925	Facial augmentation implant prosthesis	$200	Not Covered		
D5926	Nasal prosthesis, replacement	$200	Not Covered		
D5927	Auricular prosthesis, replacement	$200	Not Covered		
D5928	Orbital prosthesis, replacement	$200	Not Covered		
D5929	Facial prosthesis, replacement	$200	Not Covered		
D5931	Obturator prosthesis, surgical	$350	Not Covered		
D5932	Obturator prosthesis, definitive	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5933	Obturator prosthesis, modification	$150	Not Covered	*2 per 12 months*	
D5934	Mandibular resection prosthesis with guide flange	$350	Not Covered		
D5935	Mandibular resection prosthesis without guide flange	$350	Not Covered		
D5936	Obturator prosthesis, interim	$350	Not Covered		
D5937	Trismus appliance (not for TMD treatment)	$85	Not Covered		
D5951	Feeding aid	$135	Not Covered		
D5952	Speech aid prosthesis, pediatric	$350	Not Covered		
D5953	Speech aid prosthesis, adult	$350	Not Covered		
D5954	Palatal augmentation prosthesis	$135	Not Covered		
D5955	Palatal lift prosthesis, definitive	$350	Not Covered		
D5958	Palatal lift prosthesis, interim	$350	Not Covered		
D5959	Palatal lift prosthesis, modification	$145	Not Covered	*2 per 12 months*	
D5960	Speech aid prosthesis, modification	$145	Not Covered	*2 per 12 months*	
D5982	Surgical stent	$70	Not Covered		
D5983	Radiation carrier	$55	Not Covered		
D5984	Radiation shield	$85	Not Covered		
D5985	Radiation cone locator	$135	Not Covered		
D5986	Fluoride gel carrier	$35	Not Covered		
D5987	Commissure splint	$85	Not Covered		
D5988	Surgical splint	$95	Not Covered		
D5991	Vesiculobullous disease medicament carrier	$70	Not Covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not Covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6000-D6199 VIII. IMPLANT SERVICES					
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6011	Surgical access to an implant body (second stage implant surgery)	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6013	Surgical placement of mini implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6040	Surgical placement: eposteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6050	Surgical placement: transosteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6055	Connecting bar - implant supported or abutment supported	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6056	Prefabricated abutment - includes modification and placement	$135	Not Covered	*A Benefit only under exceptional medical conditions*	
D6057	Custom fabricated abutment - includes placement	$180	Not Covered	*A Benefit only under exceptional medical conditions*	
D6058	Abutment supported porcelain/ceramic crown	$320	Not Covered	*A Benefit only under exceptional medical conditions*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not Covered	*A Benefit only under exceptional medical conditions*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6064	Abutment supported cast metal crown (noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6065	Implant supported porcelain/ceramic crown	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6067	Implant supported crown - high noble alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not Covered	*A Benefit only under exceptional medical conditions*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not Covered	*A Benefit only under exceptional medical conditions*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not Covered	*A Benefit only under exceptional medical conditions*	
D6075	Implant supported retainer for ceramic FPD	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	Not Covered	*A Benefit only under exceptional medical conditions*	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	Not Covered	*A Benefit only under exceptional medical conditions*	
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions.*	
D6083	Implant supported crown - porcelain fused to noble alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6085	Provisional implant crown	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6086	Implant supported crown - predominantly base alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6087	Implant supported crown - noble alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6088	Implant supported crown - titanium and titanium alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6090	Repair implant supported prosthesis, by report	$65	Not Covered	*A Benefit only under exceptional medical conditions*	
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	Not Covered	*A Benefit only under exceptional medical conditions*	
D6092	Re-cement or re-bond implant/abutment supported crown	$25	Not Covered	*A Benefit only under exceptional medical conditions*	
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	Not Covered	*A Benefit only under exceptional medical conditions*	
D6094	Abutment supported crown - titanium and titanium alloys	$295	Not Covered	*A Benefit only under exceptional medical conditions*	
D6095	Repair implant abutment, by report	$65	Not Covered	*A Benefit only under exceptional medical conditions*	
D6096	Remove broken implant retaining screw	$60	Not Covered	*A Benefit only under exceptional medical conditions*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6100	Surgical removal of implant body	$110	Not Covered	*A Benefit only under exceptional medical conditions*	
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6190	Radiographic/surgical implant index, by report	$75	Not Covered	*A Benefit only under exceptional medical conditions*	
D6191	Semi-precision abutment - placement	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6192	Semi-precision attachment - placement	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	Not Covered	*A Benefit only under exceptional medical conditions*	
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6199	Unspecified implant procedure, by report	$350	Not Covered	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*	
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.					
D6205	Pontic - indirect resin based composite	Not Covered	$165		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not Covered	$300		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6212	Pontic - cast noble metal	Not Covered	$300		*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6252	Pontic - resin with noble metal	Not Covered	$300		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not Covered	$200		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not Covered	$200		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6710	Retainer crown - indirect resin based composite	Not Covered	$200		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not Covered	$300		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not Covered	$300		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$40	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	$95		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6999	Unspecified fixed prosthodontic procedure, by report	$350	$400	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.					
D7111	Extraction, coronal remnants - deciduous tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	$65		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	$115		
D7220	Removal of impacted tooth - soft tissue	$95	$85		
D7230	Removal of impacted tooth - partially bony	$145	$145		
D7240	Removal of impacted tooth - completely bony	$160	$160		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	$175		
D7250	Removal of residual tooth roots (cutting procedure)	$80	$75		
D7260	Oroantral fistula closure	$280	Not Covered		
D7261	Primary closure of a sinus perforation	$285	Not Covered		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*	
D7280	Exposure of an unerupted tooth	$220	$220		
D7283	Placement of device to facilitate eruption of impacted tooth	$85	$85	*For active orthodontic treatment only*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	Not Covered	*1 per arch per date of service; regardless of number of areas involved*	
D7286	Incisional biopsy of oral tissue-soft	$110	$110	*3 per date of service*	
D7290	Surgical repositioning of teeth	$185	Not Covered	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	Not Covered	*1 per arch; applies to active orthodontic treatment*	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	$85		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	$50		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	$120		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	$65		
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	Not Covered	*1 per arch per 60 months*	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	Not Covered	*1 per arch*	
D7410	Excision of benign lesion up to 1.25 cm	$75	Not Covered		
D7411	Excision of benign lesion greater than 1.25 cm	$115	Not Covered		
D7412	Excision of benign lesion, complicated	$175	Not Covered		
D7413	Excision of malignant lesion up to 1.25 cm	$95	Not Covered		
D7414	Excision of malignant lesion greater than 1.25 cm	$120	Not Covered		
D7415	Excision of malignant lesion, complicated	$255	Not Covered		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	Not Covered		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	Not Covered		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	$180		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	$330		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	Not Covered		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	Not Covered		
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140	*1 per quadrant*	
D7472	Removal of torus palatinus	$145	$140	*1 per lifetime*	
D7473	Removal of torus mandibularis	$140	$140	*1 per quadrant*	
D7485	Reduction of osseous tuberosity	$105	Not Covered	*1 per quadrant*	
D7490	Radical resection of maxilla or mandible	$350	Not Covered		
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	$55	*1 per quadrant per date of service*	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	Not Covered	*1 per quadrant per date of service*	
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	Not Covered		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	Not Covered		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	Not Covered	*1 per date of service*	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	Not Covered	*1 per date of service*	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	Not Covered	*1 per quadrant per date of service*	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	Not Covered		
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	Not Covered		
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	Not Covered		
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	Not Covered		
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	Not Covered		
D7650	Malar and/or zygomatic arch - open reduction	$350	Not Covered		
D7660	Malar and/or zygomatic arch - closed reduction	$350	Not Covered		
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	Not Covered		
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	Not Covered		
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7710	Maxilla - open reduction	$110	Not Covered		
D7720	Maxilla - closed reduction	$180	Not Covered		
D7730	Mandible - open reduction	$350	Not Covered		
D7740	Mandible - closed reduction	$290	Not Covered		
D7750	Malar and/or zygomatic arch - open reduction	$220	Not Covered		
D7760	Malar and/or zygomatic arch - closed reduction	$350	Not Covered		
D7770	Alveolus - open reduction stabilization of teeth	$135	Not Covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	Not Covered		
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	Not Covered		
D7810	Open reduction of dislocation	$350	Not Covered		
D7820	Closed reduction of dislocation	$80	Not Covered		
D7830	Manipulation under anesthesia	$85	Not Covered		
D7840	Condylectomy	$350	Not Covered		
D7850	Surgical discectomy, with/without implant	$350	Not Covered		
D7852	Disc repair	$350	Not Covered		
D7854	Synovectomy	$350	Not Covered		
D7856	Myotomy	$350	Not Covered		
D7858	Joint reconstruction	$350	Not Covered		
D7860	Arthrotomy	$350	Not Covered		
D7865	Arthroplasty	$350	Not Covered		
D7870	Arthrocentesis	$90	Not Covered		
D7871	Non-arthroscopic lysis and lavage	$150	Not Covered		
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	Not Covered		
D7873	Arthroscopy: lavage and lysis of adhesions	$350	Not Covered		
D7874	Arthroscopy: disc repositioning and stabilization	$350	Not Covered		
D7875	Arthroscopy: synovectomy	$350	Not Covered		
D7876	Arthroscopy: discectomy	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7877	Arthroscopy: debridement	$350	Not Covered		
D7880	Occlusal orthotic device, by report	$120	Not Covered		
D7881	Occlusal orthotic device adjustment	$30	Not Covered	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*	
D7899	Unspecified TMD therapy, by report	$350	Not Covered		
D7910	Suture of recent small wounds up to 5 cm	$35	Not Covered		
D7911	Complicated suture - up to 5 cm	$55	Not Covered		
D7912	Complicated suture - greater than 5 cm	$130	Not Covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not Covered		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	$80		
D7940	Osteoplasty - for orthognathic deformities	$160	Not Covered		
D7941	Osteotomy - mandibular rami	$350	Not Covered		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	Not Covered		
D7944	Osteotomy - segmented or subapical	$275	Not Covered		
D7945	Osteotomy - body of mandible	$350	Not Covered		
D7946	LeFort I (maxilla - total)	$350	Not Covered		
D7947	LeFort I (maxilla - segmented)	$350	Not Covered		
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	Not Covered		
D7949	LeFort II or LeFort III - with bone graft	$350	Not Covered		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	Not Covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not Covered		
D7952	Sinus augmentation via a vertical approach	$175	Not Covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not Covered		
D7961	Buccal/labial frenectomy (frenulectomy)	$120	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7962	Lingual frenectomy (frenulectomy)	$120	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	
D7963	Frenuloplasty	$120	Not Covered	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	
D7970	Excision of hyperplastic tissue - per arch	$175	$176	*1 per arch per date of service*	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of fibrous tuberosity	$100	Not Covered	*1 per quadrant per date of service*	
D7979	Non-surgical sialolithotomy	$155	Not Covered		
D7980	Sialolithotomy	$155	Not Covered		
D7981	Excision of salivary gland, by report	$120	Not Covered		
D7982	Sialodochoplasty	$215	Not Covered		
D7983	Closure of salivary fistula	$140	Not Covered		
D7990	Emergency tracheotomy	$350	Not Covered		
D7991	Coronoidectomy	$345	Not Covered		
D7995	Synthetic graft - mandible or facial bones, by report	$150	Not Covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not Covered	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D7999	Unspecified oral surgery procedure, by report	$350	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY					
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.					
- Pediatric Enrollee must continue to be eligible. Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.					
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.					
- Copayment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Copayment applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.					
- Refer to Schedule B for additional information on medically necessary orthodontics.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	Not Covered	*1 per Enrollee per phase of treatment*	
D8210	Removable appliance therapy			*1 per lifetime; age 6 through 12*	
D8220	Fixed appliance therapy			*1 per lifetime; age 6 through 12*	
D8660	Pre-orthodontic treatment examination to monitor growth and development			*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*	
D8670	Periodic orthodontic treatment visit			*Included in comprehensive case fee*	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))			*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*	
D8681	Removable orthodontic retainer adjustment				
D8696	Repair of orthodontic appliance - maxillary			*1 per appliance; included in comprehensive case fee*	
D8697	Repair of orthodontic appliance - mandibular			*1 per appliance; included in comprehensive case fee*	
D8698	Re-cement or re-bond fixed retainer - maxillary			*1 per Contract Dentist; included in comprehensive case fee*	
D8699	Re-cement or re-bond fixed retainer - mandibular			*1 per Contract Dentist; included in comprehensive case fee*	
D8701	Repair of fixed retainer, includes reattachment - maxillary			*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*	
D8702	Repair of fixed retainer, includes reattachment - mandibular			*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*	
D8703	Replacement of lost or broken retainer - maxillary			*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8704	Replacement of lost or broken retainer - mandibular			*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*	
D8999	Unspecified orthodontic procedure, by report			*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	$28	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*	
D9120	Fixed partial denture sectioning	$95	Not Covered		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	Not Covered	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15		
D9222	Deep sedation/general anesthesia - first 15 minutes	$45	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	Not Covered	*(Where available)*	
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9248	Non-intravenous conscious sedation	$65	Not Covered	*Where available; 1 per date of service per Contract Dentist*	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	$45		
D9311	Consultation with a medical health professional	No charge	No charge		
D9410	House/extended care facility call	$50	Not Covered	*1 per Enrollee per date of service*	
D9420	Hospital or ambulatory surgical center call	$135	Not Covered		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	$12	*1 per date of service per Contract Dentist*	
D9440	Office visit - after regularly scheduled hours	$45	$40	*1 per date of service per Contract Dentist*	
D9450	Case presentation, detailed and extensive treatment planning	Not Covered	No charge		
D9610	Therapeutic parenteral drug, single administration	$30	Not Covered	*4 of (D9610, D9612) injections per date of service*	
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	Not Covered	*4 of (D9610, D9612) injections per date of service*	
D9910	Application of desensitizing medicament	$20	Not Covered	*1 per 12 months per Contract Dentist; permanent teeth*	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	Not Covered	*1 per date of service per Contract Dentist within 30 days of an extraction*	
D9943	Occlusal guard adjustment	Not Covered	$35		*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9945	Occlusal guard - soft appliance, full arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9946	Occlusal guard - hard appliance, partial arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9950	Occlusion analysis - mounted case	$120	Not Covered	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9951	Occlusal adjustment - limited	$45	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*	
D9952	Occlusal adjustment - complete	$210	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9995	Teledentistry - synchronous; real-time encounter	Not Covered	No charge		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Not Covered	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9997	Dental case management - patients with special health care needs	No charge	No charge		
D9999	Unspecified adjunctive procedure, by report	No charge	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment(s) specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the assigned Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Copayment(s) for the covered procedure.

Example of an Optional or upgraded procedure:

- If You chose an Optional or upgraded procedure presented by the Contract Dentist,
  - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer; and
  - An additional laboratory fee is charged by the Contract Dentist

  Then You will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

<u>Additional Endnotes to Covered California's 2023 Dental Standard Benefit Plan Designs</u>
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

1. 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.
2. 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.
3. 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.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

1. Tooth whitening, adult orthodontia, implants, veneers and adult services noted as Not Covered on the Copayment Schedule are not covered services.

SCHEDULE B
Limitations and Exclusions of Benefits
Delta Dental of California
Family Dental HMO

Limitations and Exclusions of Benefits for Adult Enrollees (Age 19 and older)

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments* ("Schedule A"). Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240 and D7241).
4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Contact Delta Dental at 888-282-8528 if you have questions regarding the additional fee or name brand services.
5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.
6. Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*.
2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the TMJ, with the exception of procedures as shown on *Schedule A*.
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations or other diagnostic services for non-covered Benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized Contract Specialist (oral surgeon, endodontist, periodontist, pediatric dentist) or Contract Orthodontist except for "Emergency Dental Services" as described in this Policy.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription and over-the-counter drugs.
12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with this Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic Treatment in Progress provision.
13. Changes in orthodontic treatment necessitated by accident of any kind.
14. Myofunctional and parafunctional appliances and/or therapies, with the exception of as procedures shown on *Schedule A.*
15. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

<u>Limitations of Benefits for Pediatric Enrollees</u>

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A.* Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. A filling (D2140-D2161, D2330-D2335, D2391-D2394) is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown (D2390 and covered codes only between D2710-D2791) is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.
4. The replacement of an existing crown (D2390 and covered codes only between D2710-D2791), fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or a removable full (D5110, D5120) or partial denture (covered codes only between D5211-D5214, D5221-D5224) is covered when:
   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
5. Coverage for the placement of a fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or removable partial denture (covered codes only between D5211-D5214, D5221-D5224):
   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
      - Each abutment tooth to be crowned meets Limitation #3.
   b. Removable partial denture:
      - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
6. Immediate dentures (D5130, D5140, D5221-D5224) are covered when one or more of the following conditions are present:
   a. extensive or rampant caries are exhibited in the radiographs, or
   b. severe periodontal involvement indicated, or
   c. numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.
7. Maxillofacial prosthetic services (covered codes only between D5911-D5999) for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
8. All maxillofacial prosthetic procedures (covered codes only between D5911-D5999) require prior Authorization for medically necessary procedures.

9. Implant services (covered codes only between D6010-D6199) are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
    a. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures (D7340, D7350) or osseous augmentation procedures (D7950), and the Enrollee is unable to function with conventional prosthesis.
    c. skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
10. Temporomandibular joint dysfunction procedure codes (covered codes only between D7810-D7880) are limited to differential diagnosis and symptomatic care and require prior Authorization.
11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.
12. Deep sedation/general anesthesia (D9222, D9223) or intravenous conscious sedation/analgesia D9239, D9243) for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

<u>Exclusions of Benefits for Pediatric Enrollees</u>

1. Any procedure that is not specifically listed under *Schedule A*, except as required by state or federal law.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or theft of full or partial dentures (covered codes only between D5110, D5120, D5130, D5140, D5211-D5214, D5221-D5224), space maintainers (D1510-D1575), crowns (D2390 and covered codes only between D2710-D2791), fixed partial dentures (bridges) (covered codes only between D6211-D6245, D6251, D6721-D6791) or other appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
6. Congenital malformations (e.g., congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.
7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.
8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    b. is inconsistent with generally accepted standards for dentistry.
9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a Contract Specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" provisions of the Policy. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 888-282-8528.
10. Consultations (D9310, D9311) or other diagnostic services (covered codes only between D0120-D0999), for non-covered Benefits.
11. Single tooth implants (covered codes only between D6000-D6199).
12. Restorations (covered codes only between D2330-D2335, D2391-D2394, D2710-D2792, D6211-D6245, D6251, D6721-D6791) placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
13. Preventive (covered codes only between D1110-D1575), endodontic (covered codes only between D3110-D3999) or restorative (covered codes only between D2140-D2999) procedures are not a Benefit for teeth to be retained for overdentures.
14. Partial dentures (covered codes only between D5211-5214, D5221-D5224) are not a Benefit to replace missing 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.
15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth (covered codes only between D8000-D8999), periodontal splinting (D4322-D4323), gnathologic recordings,

equilibration (D9952) or treatment of disturbances of the TMJ (covered codes only between D0310-D0322, D7810-D7899), unless included in *Schedule A*.

16. Porcelain denture teeth, or fixed partial dentures (overlays, implants, and appliances associated therewith) (D6940, D6950) and personalization and characterization of complete and partial dentures.
17. Extraction of teeth (D7111, D7140, D7210, D7220-D7240, D7241, D7250), when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
18. TMJ dysfunction treatment modalities that involve prosthodontia (D5110-D5224, D6211-D6245, D6251, D6721-D6791), orthodontia (covered codes only between D8000-D8999), and full or partial occlusal rehabilitation or TMJ dysfunction procedures (covered codes only between D0310-D0322, D7810-D7899) solely for the treatment of bruxism.
19. Vestibuloplasty/ridge extension procedures (D7340, D7350) performed on the same date of service as extractions (D7111-D7250) on the same arch.
20. Deep sedation/general anesthesia (D9222, D9223) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia (D9239, D9243).
21. Intravenous conscious sedation/analgesia (D9239, D9243) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia (D9222, D9223).
22. Inhalation of nitrous oxide (D9230) when administered with other covered sedation procedures.
23. Cosmetic dental care (exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710-D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999).

Medically Necessary Orthodontics for Pediatric Enrollees

1. Orthodontic Services are limited to the following automatic qualifying conditions:
   a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
   b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
   c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
   d. A crossbite of individual anterior teeth causing destruction of soft tissue,
   e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
   f. Severe traumatic deviation.

2. The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:
   a. ADA 2006 or newer claim form with service code(s) requested;
   b. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   c. Cephalometric radiographic image or panoramic radiographic image;
   d. HLD score sheet completed and signed by the Contract Orthodontist; and
   e. Treatment plan.

3. Coverage for comprehensive orthodontic treatment (D8080) requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (“HLD”) Index California Modification Score Sheet Form and pre-treatment diagnostic casts (D0470). Comprehensive orthodontic treatment (D8080):
   a. is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b. may start at birth for patients with a cleft palate or craniofacial anomaly.

4. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollees between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

5. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0351, D0703, D0704). Neither the Enrollee nor the plan may be charged for D0350, D0351, D0703 or D0704 in conjunction with a pre-orthodontic treatment examination.

6. The number of covered periodic orthodontic treatment visits (D8670) and length of covered active orthodontics is limited to a maximum of up to:

   a. handicapping malocclusion - eight (8) quarterly visits;
   b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
   c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
   d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
   e. facial growth management - four (4) quarterly visits for treatment of primary dentition;
   f. facial growth management - five (5) quarterly visits for treatment of mixed dentition;
   g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.

7. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment (D8080) which:

   a. includes removal of appliances and the construction and place of retainer(s) (D8680); and
   b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

8. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment (covered codes only between D8000-D8999). If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and
   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

9. Should an Enrollee’s coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment (covered codes only between D8000-D8999), the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

   a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
   b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

   At the end of 60 days (or at the end of the quarter), the Enrollee’s obligation shall be based on the Contract Orthodontist’s submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

10. Orthodontics, including oral evaluations and all treatment, (covered codes only between D8000-D8999) must be performed by a licensed Dentist or their supervised staff, acting within the scope of applicable law.

11. The removal of fixed orthodontic appliances (D8680) for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Plan

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Annual Out-of-Pocket Maximum	Individual $350.00 Multiple Child $700.00
(D) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in *Schedule A, Description of Benefits and Copayments*, subject to the limitations and exclusions of this Plan. Copayments range by category of service. Examples are as follows: Diagnostic Services: No Charge Preventive Services: No Charge Restorative Services: $ 20.00 - $ 310.00 Endodontic Services: $ 20.00 - $ 365.00 Periodontic Services: $ 10.00 - $ 350.00 Prosthodontic Services (removable): $ 20.00 - $ 350.00 Maxillofacial Prosthetics: $ 35.00 - $ 350.00 Implant Services (medically necessary only): $ 25.00 - $ 350.00 Prosthodontic Services (fixed): $ 40.00 - $ 350.00 Oral and Maxillofacial Surgery: $ 30.00 - $ 350.00 Orthodontic Services (medically necessary only): $ 350.00 Adjunctive General Services: No Charge - $ 210.00 **NOTE:** Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Copayment that is shown in *Schedule A, Description of Benefits and Copayments* in the Policy.

Service Areas

Coverage is available in the following counties in California:

Full counties (plan available anywhere in the county):

Alameda

Amador

Colusa

Contra Costa

Glenn

Kings

Lake

Los Angeles

Madera

Marin

Merced

Monterey

Napa

Orange

Sacramento

San Benito

San Francisco

San Joaquin

San Luis Obispo

San Mateo

Santa Barbara

Santa Clara

Santa Cruz

Solano

Stanislaus

Sutter

Tulare

Ventura

Yolo

Yuba

Partial counties (plan only available in certain areas of the county):

Butte

Calaveras

El Dorado

Fresno

Humboldt

Imperial

Inyo

Kern

Mariposa

Mendocino

Nevada

Placer

Plumas

Riverside

San Bernardino

San Diego

Shasta

Sierra

Sonoma

Tehama

Trinity

Tuolumne

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 888-282-8528 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 888-282-8528 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 888-282-8528 (TTY: 711)。(Chinese)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 888-282-8528 (TTY: 711). (Tagalog)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 888-282-8528 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 888-282-8528 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 888-282-8528 (TTY՝ 711): (Armenian)

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هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 888-282-8528 (TTY: 711). (Arabic)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 888-282-8528 (телетайп: 711). (Russian)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 888-282-8528 (TTY: 711)। (Hindi)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 888-282-8528 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 888-282-8528 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 888-282-8528 (TTY: 711)។ (Cambodian)

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