

Attachment A

Deductibles, Maximums, Policy Benefit Levels and Enrollee Coinsurances

Summary of Benefits and Coverage		Family Dental Plan			
		Coinsurance Plan			
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental Essential Health Benefits		Adult Dental	
		Up to Age 19		Age 19 and Older	
Actuarial Value		85.44%	85.44%	Not Calculated	Not Calculated
		In-Network: Delta Dental PPO ¹	Out-of- Network: Non- Delta Dental PPO ¹	In-Network: Delta Dental PPO ¹	Out-of- Network: Non- Delta Dental PPO ¹
Individual Deductible each Calendar Year ^{2,3}		\$75	\$75	\$50	\$50
Family Deductible each Calendar Year (Two or more children) ³		\$150	\$150	Not Applicable	Not Applicable
Individual Out of Pocket Maximum each Calendar Year ⁴		\$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum each Calendar Year (Two or More Children) ⁴		\$700	None	Not Applicable	Not Applicable
Office Copay		\$0	\$0	\$0	\$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))		None	None	Major Services limited to enrollees who have been enrolled in the Policy for 6 consecutive months, waived with proof of prior coverage ⁵	Major Services limited to enrollees who have been enrolled in the Policy for 6 consecutive months, waived with proof of prior coverage ⁵
Annual Benefit Limit (the maximum amount the dental plan will pay in the Calendar Year)		None	None	\$1,500	
Procedure Category	Service Type	Member Cost Share ⁶	Member Cost Share ⁶	Member Cost Share ⁶	Member Cost Share ⁶
	Oral Exam	No charge	10%	No charge	10%

Diagnostic & Preventive	Preventive - Cleaning	No charge	10%	No charge	10%
	Preventive - X-ray	No charge	10%	No charge	10%
	Sealants per Tooth	No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics				
	Crowns and Casts				
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia ⁷	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

¹ Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

² Each adult is responsible for an individual Deductible. Adult Deductible is waived for Diagnostic and Preventive Services.

³ In a coinsurance plan, each child is responsible for the individual Deductible unless the family Deductible has been met. Once a child's individual Deductible or the family Deductible is reached, cost sharing applies until the child's Out-of-Pocket Maximum is reached.

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.

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.

Pediatric Deductible is waived for Diagnostic and Preventive Services.

⁴ Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by Delta Dental PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollee(s) equals the Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services received from Delta Dental PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Delta Dental Premier or Non-Delta Dental PPO Providers even after the Out-of-Pocket Maximum is met.

If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from Delta Dental PPO Providers is not more than the multiple Pediatric Enrollees Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied their Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from Delta Dental PPO Providers until the total amount paid reaches the Out-of-Pocket Maximum for multiple Pediatric Enrollees.

- ⁵ The six month waiting period (Adult only) for major services must be waived upon a member's provision of proof of prior comparable dental coverage. This waiting period shall be prorated on a one to one monthly basis upon a member's provision of proof of prior comparable dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month waiting period would no longer occur. Dental services obtained via a discount health plan are not considered "comparable" dental coverage for purposes of counting towards the waiting period.
- ⁶ Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: Policy Benefit Levels differ between Delta Dental PPO Providers and Non-Delta Dental PPO Providers. The greatest benefits – including out-of-pocket savings – occur when covered services are received by a Delta Dental PPO Provider. The amount charged to Enrollees for covered services performed by a Non-Delta Dental PPO Provider may be above that accepted by Delta Dental PPO Providers, and Enrollees will be responsible for balance billed amounts.
- ⁷ Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Attachment B

Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (age 19 and older)

Delta Dental will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- Diagnostic and Preventive Services

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment, including x-rays and oral exams.
- (2) Preventive: cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Service for payment purposes).
- (3) Specialist Consultations: opinion or advice requested by a general dentist.

- Basic Services

- (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- (2) Periodontal Cleanings: periodontal maintenance.
- (3) Palliative: emergency treatment to relieve pain.
- (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- Major Services

- (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges.
- (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
- (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (5) Periodontics: treatment of gums and bones supporting teeth.
- (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.

- Note on additional Benefits during pregnancy

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations for Adult Benefits (age 19 and older)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

- a) a composite restoration instead of an amalgam restoration on posterior teeth;
- b) a crown where a filling would restore the tooth;
- c) an inlay/onlay instead of an amalgam restoration; or
- d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Delta Dental will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a calendar year.
- (3) Delta Dental will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year. A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- (4) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
- (5) A caries risk assessment is allowed once in 12 months. An interim caries arresting medicament application is covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.
- (6) X-ray limitations:
 - a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are not billable to the Enrollee or Delta Dental within 12 months of a full mouth series unless warranted by special circumstances.
 - f) Image capture procedures are not separately allowable service.
- (7) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (8) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (9) Delta Dental will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.
- (10) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

- (11) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (12) Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.
- (13) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (14) Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete endodontic therapy; inoperable, unrestorable or fractured tooth are limited to once in a lifetime.
- (15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (16) Pin retention is covered not more than once in any 24-month period.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (18) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.
 - b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
 - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
 - d) Guided tissue regeneration is not benefited in conjunction with soft tissue grafts in the same surgical area.
 - e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
 - f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- (19) Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.
- (20) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.
- (21) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (22) Core buildup, including any pins, is covered not more than once in any 60 month period.
- (23) Post and core services are covered not more than once in any 60 month period.
- (24) Crown repairs are covered not more than once in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for twenty-four (24) months following installation.
- (25) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

- (26) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.
- (27) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance is not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
- (28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- (29) Recementation of Crowns, Inlays/Onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- (30) The initial installation of a prosthodontic appliance is not a Benefit unless the prosthodontic appliance, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.
- (31) Occlusal adjustment - limited, is allowed once in a 60-month period.
- (32) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
 - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
 - c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.
 - d) Recementation of fixed partial dentures is limited to once in a lifetime.
- (33) Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.
- (34) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not separately payable service.

Exclusions for Adult Benefits (age 19 and older)

Delta Dental does not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons, including teeth whitening and veneers.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations.

- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (12) indirectly fabricated resin-based Inlays/Onlays.
- (13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (14) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (15) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (16) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (19) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (20) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (21) the initial placement of any prosthodontic appliance, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- (22) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- (23) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

- (24) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.
- (25) missed and/or cancelled appointments.
- (26) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (27) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (28) dental case management motivational interviewing and patient education to improve oral health literacy.
- (29) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (30) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (31) diabetes testing.
- (32) corticotomy (specialized oral surgery procedures associated with orthodontics).
- (33) Antigen or antibody testing.
- (34) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Description of Dental Services for Pediatric Benefits (under age 19)

Delta Dental will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for Essential Health Benefits and benefits listed below in the Schedule of Covered Services when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a 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. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- Diagnostic and Preventive Services
 - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment, including x-rays and oral exams.
 - (2) Preventive: cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
 - (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
 - (4) Specialist Consultations: opinion or advice requested by a general dentist.
- Basic Services
 - (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
 - (2) Periodontal Cleanings: periodontal maintenance.
 - (3) Palliative: emergency treatment to relieve pain.
 - (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- Major Services
 - (1) Crowns: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
 - (2) Prosthodontics: procedures for construction of partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
 - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
 - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
 - (5) Periodontics: treatment of gums and bones supporting teeth.
 - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- Note on Early Periodic Screening, Diagnosis and Treatment (EPSDT) Benefit.
Administration of this plan design 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.
- Note on additional Benefits during pregnancy
When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Schedule of Covered Services

The Procedure Codes and nomenclature in this schedule are copyright of the American Dental Association. This table represents Procedure Codes and nomenclature excerpted from the version of Current Dental Terminology (CDT®) in effect at the date of this printing. Delta Dental's administration of Benefits, limitations and exclusions under this Plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Procedure Code	Procedure Description and Limitations
<u>Diagnostic and Preventive Services</u>	
D0120	Periodic oral evaluation - established patient: once every 6 months per provider
D0140	Limited oral evaluation - problem focused: once per patient per provider
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient: once per patient per provider
D0160	Detailed and extensive oral evaluation - problem focused, by report: once per patient per provider
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit): 6 in 3 months, not to exceed 12 in 12 months
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images: once per provider every 36 months
D0220	Intraoral - periapical first radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0230	Intraoral - periapical each additional radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0240	Intraoral - occlusal radiographic image: maximum of 2 in 6 months per provider

D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector: once per date of service
D0251	Extra-oral posterior dental radiographic image: 4 per date of service
D0270	Bitewing - single radiographic image: once per date of service
D0272	Bitewings - two radiographic images: once every 6 months per provider
D0273	Bitewings - three radiographic image
D0274	Bitewings - four radiographic images: once every 6 months per provider, age 10 and older
D0277	Vertical bitewings - 7 to 8 radiographic images: maximum of 4
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection: maximum of 3 per date of service
D0322	Tomographic survey: twice in 12 months per provider
D0330	Panoramic radiographic image: once in 36 months per provider
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis: twice in 12 months per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally: maximum of 4 per date of service
D0351	3D photographic image: once per date of service
D0460	Pulp vitality tests
D0470	Diagnostic casts: once per provider
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0602	Caries risk assessment and documentation, with a finding of moderate risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0603	Caries risk assessment and documentation, with a finding of high risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0701	Panoramic radiographic image – image capture only
D0702	2-D cephalometric radiographic image – image capture only
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
D0704	3-D photographic image – image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only
D0706	Intraoral – occlusal radiographic image – image capture only
D0707	Intraoral – periapical radiographic image – image capture only
D0708	Intraoral – bitewing radiographic image – image capture only
D0709	Intraoral – complete series of radiographic images – image capture only
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult: once every 6 months
D1120	Prophylaxis - child: once every 6 months
D1206	Topical application of fluoride varnish: once every 6 months and frequency limitation applies towards D1208
D1208	Topical application of fluoride – excluding varnish: once every 6 months and frequency limitation applies towards D1206
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330	Oral hygiene instructions

D1351	Sealant - per tooth: once per permanent molar every 36 months per provider if they are without caries (decay) or restorations on the occlusal surface.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth: once per tooth every 36 months per provider
D1353	Sealant repair - per tooth
D1354	Interim caries arresting medicament application - per tooth: once every 6 months
D1355	Caries preventive medicament application – per tooth
D1510	Space maintainer - fixed - unilateral- per quadrant: once per quadrant per patient through age 17
D1516	Space maintainer - fixed – bilateral, maxillary: once per arch per patient through age 17
D1517	Space maintainer - fixed – bilateral, mandibular: once per arch per patient through age 17
D1520	Space maintainer - removable - unilateral- per quadrant: once per quadrant per patient through age 17
D1526	Space maintainer - removable – bilateral, maxillary: once per arch per patient through age 17
D1527	Space maintainer - removable – bilateral, mandibular: once per arch per patient through age 17
D1551	Re-cement or re-bond bilateral space maintainer – maxillary: once per provider per quadrant or arch through age 17
D1552	Re-cement or re-bond bilateral space maintainer - mandibular: once per provider per quadrant or arch through age 17
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant: once per provider per quadrant or arch through age 17
D1556	Removal of fixed unilateral space maintainer - per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer - mandibular
D1575	Distal shoe space maintainer – fixed, unilateral- per quadrant: once per quadrant per lifetime; under age 9
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation: once every 6 months
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health care professional
D9997	Dental case management - patients with special health care needs
<u>Basic Services</u>	
D2140	Amalgam - one surface, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2150	Amalgam - two surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2160	Amalgam - three surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2161	Amalgam - four or more surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2330	Resin-based composite - one surface, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior): once in 12 months for primary teeth, once in 36 months for permanent teeth
D2390	Resin-based composite crown, anterior: once in 12 months for primary teeth , once in 36 months for permanent teeth
D2391	Resin-based composite - one surface, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth

D2392	Resin-based composite - two surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2393	Resin-based composite - three surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration: once in 12 months per provider
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core: performed in conjunction with recementation of existing or new crown and is not separately payable
D2920	Re-cement or re-bond crown
D2921	Reattachment of tooth fragment, incisal edge or cusp: once in 12 months.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth
D2929	Prefabricated porcelain/ceramic crown – primary tooth: once in 12 months
D2930	Prefabricated stainless steel crown - primary tooth: once in 12 months
D2931	Prefabricated stainless steel crown - permanent tooth; once in 36 months
D2932	Prefabricated resin crown: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2933	Prefabricated stainless steel crown with resin window: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2940	Protective restoration: once per tooth in 6 months per provider
D2941	Interim therapeutic restoration - primary dentition: once per tooth in 6 months per provider
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration: once per tooth for permanent teeth
D2952	Post and core in addition to crown, indirectly fabricated: once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown: once per tooth
D2955	Post removal
D2957	Each additional prefabricated post - same tooth
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework
D2980	Crown repair necessitated by restorative material failure
D2999	Unspecified restorative procedure, by report
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal maintenance: once in a calendar quarter and only in the 24 months following the last scaling and root planing, age 13+
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: once per tooth in 24 months
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D9110	Palliative (emergency) treatment of dental pain - minor procedure: once per date of service per provider regardless of the number of teeth and/or areas treated
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures: once per date of service per provider
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each 15 minute increment
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia

D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248	Non-intravenous conscious sedation: once per date of service
D9410	House/extended care facility call: once per patient per date of service
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed: once per date of service per provider
D9440	Office visit - after regularly scheduled hours: once per date of service per provider
D9610	Therapeutic parenteral drug, single administration: maximum of 4 injections per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different medications
D9910	Application of desensitizing medicament: once in 12 months per provider for permanent teeth
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report: once per date of service per provider
D9951	Occlusal adjustment - limited: once in 12 months, age 13+
D9999	Unspecified adjunctive procedure, by report
<u>Major Services</u>	
D2710	Crown - resin-based composite (indirect): once in 5 years, age 13+
D2712	Crown - 3/4 resin-based composite (indirect): once in 5 years, age 13+
D2721	Crown - resin with predominantly base metal: once in 5 years, age 13+
D2740	Crown - porcelain/ceramic substrate: once in 5 years, age 13+
D2751	Crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D2781	Crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D2783	Crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D2791	Crown - full cast predominantly base metal: once in 5 years, age 13+
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament: once per primary tooth
D3221	Pulpal debridement, primary and permanent teeth: once per tooth
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development: once per permanent tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration): once per primary tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration): once per primary tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3346)
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3347)
D3330	Endodontic therapy, molar (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3348)
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - bicuspid
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.): once per permanent tooth
D3352	Apexification/recalcification - interim medication replacement: once per permanent tooth
D3410	Apicoectomy - anterior
D3421	Apicoectomy - bicuspid (first root)

D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy (each additional root)
D3430	Retrograde filling - per root
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 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: once per quadrant in 36 months, age 13+
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
D4341	Periodontal scaling and root planing - four or more teeth per quadrant: once per quadrant in 24 months; age 13+
D4342	Periodontal scaling and root planing - one to three teeth per quadrant: once per quadrant in 24 months; age 13+
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff): included in fee for completed service (D4210, D4211, D4260, D4261) if same provider. Once per patient to different provider.
D4999	Unspecified periodontal procedure, by report: age 13+
D5110	Complete denture - maxillary: once in 5 years
D5120	Complete denture - mandibular: once in 5 years
D5130	Immediate denture - maxillary: once per patient
D5140	Immediate denture - mandibular: once per patient
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth): once in 5 years
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth): once in 5 years
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5410	Adjust complete denture - maxillary: per provider, once per date of service and twice in 12 months
D5411	Adjust complete denture - mandibular: per provider, once per date of service and twice in 12 months
D5421	Adjust partial denture - maxillary: per provider, once per date of service and twice in 12 months

D5422	Adjust partial denture - mandibular: per provider, once per date of service and twice in 12 months
D5511	Repair broken complete denture base, mandibular: per provider, once per arch per date of service and twice in 12 months
D5512	Repair broken complete denture base, maxillary: per provider, once per arch per date of service and twice in 12 months
D5520	Replace missing or broken teeth - complete denture (each tooth): per provider, 4 per arch per date of service and twice per arch in 12 months
D5611	Repair resin denture base, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5612	Repair resin denture base, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5621	Repair cast partial framework, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5622	Repair cast partial framework, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5630	Repair or replace broken retentive clasping materials - per tooth: per provider, 3 per date of service and twice per arch in 12 months
D5640	Replace broken teeth - per tooth: per provider, 4 per arch per date of service and twice per arch in 12 months
D5650	Add tooth to existing partial denture: per provider, 3 per date of service and once per tooth
D5660	Add clasp to existing partial denture - per tooth: per provider, 3 per date of service and twice per arch in 12 months
D5730	Reline complete maxillary denture (direct): once in 12 months
D5731	Reline complete mandibular denture (direct): once in 12 months
D5740	Reline maxillary partial denture (direct): once in 12 months
D5741	Reline mandibular partial denture (direct): once in 12 months
D5750	Reline complete maxillary denture (indirect): once in 12 months
D5751	Reline complete mandibular denture (indirect): once in 12 months
D5760	Reline maxillary partial denture (indirect): once in 12 months
D5761	Reline mandibular partial denture (indirect): once in 12 months
D5850	Tissue conditioning, maxillary: twice per prosthesis in 36 months
D5851	Tissue conditioning, mandibular: twice per prosthesis in 36 months
D5862	Precision attachment, by report: included in fee for prosthetic and restorative procedure and not separately payable
D5863	Overdenture – complete maxillary: once in 5 years
D5864	Overdenture – partial maxillary: once in 5 years
D5865	Overdenture – complete mandibular: once in 5 years
D5866	Overdenture - partial mandibular: once in 5 years
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis

D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification: twice in 12 months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification: twice in 12 months
D5960	Speech aid prosthesis, modification: twice in 12 months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown- porcelain fused to high noble alloys

D6067	Implant supported crown- high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD- porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD- high noble alloys
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Provisional implant crown: included in fee for implant services and not separately payable
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown: once in 12 months per provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture: once in 12 months per provider
D6094	Abutment supported crown - titanium and titanium alloys
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement

D6192	Semi-precision attachment – placement
D6194	Abutment supported retainer crown for FPD- titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6199	Unspecified implant procedure, by report
D6211	Pontic - cast predominantly base metal: once in 5 years, age 13+
D6241	Pontic - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6245	Pontic - porcelain/ceramic: once in 5 years, age 13+
D6251	Pontic - resin with predominantly base metal: once in 5 years, age 13+
D6721	Retainer crown - resin with predominantly base metal: once in 5 years, age 13+
D6740	Retainer crown - porcelain/ceramic: once in 5 years, age 13+
D6751	Retainer crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6781	Retainer crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D6783	Retainer crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D6784	Retainer crown $\frac{3}{4}$ - titanium and titanium alloys: once in 5 years, age 13+
D6791	Retainer crown - full cast predominantly base metal: once in 5 years, age 13+
D6930	Re-cement or re-bond fixed partial denture: once in 12 months per same provider
D6980	Fixed partial denture repair necessitated by restorative material failure: once in 12 months of initial placement or previous repair by same provider
D6999	Unspecified fixed prosthodontic procedure, by report: once in 12 months of initial placement by same provider
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth: once per arch regardless of the number of teeth involved for permanent anterior teeth
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth
D7285	Incisional biopsy of oral tissue -hard (bone, tooth): once per arch per date of service
D7286	Incisional biopsy of oral tissue -soft: maximum of 3 per date of service
D7290	Surgical repositioning of teeth: once per arch for permanent teeth for patients in active orthodontic treatment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report: once per arch
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization): once per arch in 5 years

D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue): once per arch
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible): once per quadrant
D7472	Removal of torus palatinus: once in the patient's lifetime
D7473	Removal of torus mandibularis: once per quadrant
D7485	Reduction of osseous tuberosity: once per quadrant
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage of abscess - intraoral soft tissue: once per quadrant per same date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces): once per quadrant per same date of service
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue: once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system: once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone: once per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus closed reduction may include stabilization of teeth
D7671	Alveolus, open reduction may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction

D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy: lavage and lysis of adhesions
D7874	Arthroscopy: disc repositioning and stabilization
D7875	Arthroscopy: synovectomy
D7876	Arthroscopy: discectomy
D7877	Arthroscopy: debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment: once per date of service per provider, two in 12 months per provider
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	Lefort I (maxilla - total)
D7947	Lefort I (maxilla - segmented)
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	Lefort II or lefort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7961	Buccal / labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty: once per arch per date of service

D7970	Excision of hyperplastic tissue - per arch: once per arch per date of service
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity: once per quadrant per date of service
D7979	Non-surgical sialolithotomy
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar: once per arch per date of service
D7999	Unspecified oral surgery procedure, by report
D9950	Occlusion analysis - mounted case: once in 12 months, age 13+
D9952	Occlusal adjustment - complete: once in 12 months, age 13+
<u>Orthodontia</u>	
D8080	Comprehensive orthodontic treatment of the adolescent dentition: once per patient per phase of treatment
D8210	Removable appliance therapy: once per patient, ages 6 through 12
D8220	Fixed appliance therapy: once per patient, ages 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development: once every 3 months for a maximum of 6 during patient's lifetime
D8670	Periodic orthodontic treatment visit: once per calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s): once per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment. Included in fee for complete orthodontic service and not separately payable.
D8696	Repair of orthodontic appliance – maxillary: once per appliance
D8697	Repair of orthodontic appliance – mandibular: once per appliance
D8698	Re-cement or re-bond fixed retainer – maxillary: once per provider
D8699	Re-cement or re-bond fixed retainer – mandibular: once per provider
D8701	Repair of fixed retainer, includes reattachment – maxillary: Included in fee for complete orthodontic service and not separately payable.
D8702	Repair of fixed retainer, includes reattachment – mandibular: Included in fee for complete orthodontic service and not separately payable.
D8703	Replacement of lost or broken retainer – maxillary: once per arch
D8704	Replacement of lost or broken retainer – mandibular: once per arch
D8999	Unspecified orthodontic procedure, by report

Limitations for Pediatric Benefits (under age 19)

- (1) Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

- (2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (3) Exam(covered codes only between D0120 – D0180) and cleaning limitations(D1110, D1120):
- a) Delta Dental will pay for periodic oral examinations(D0120) (except after hours exams(D9440) and exams for observation(D9430)) no more than once every six (6) months per provider and routine cleanings(D1110, D1120), including scaling in presence of generalized moderate or severe gingival inflammation(D4346) (including periodontal maintenance(D4910) or any combination thereof) no more than once every six (6) months. Detailed(D0160), limited(D0140) and comprehensive(D0150, D0180) oral examinations are covered once per patient per provider. Re-evaluation – limited, problem focused exams (established patient; not post-operative visits)(D0170) are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12 month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation. See note on additional Benefits during pregnancy.
 - b) Periodontal maintenance(D4910) is limited to Enrollees age 13 and older once in a calendar quarter and only in the 24 months following the last scaling and root planing. A full mouth debridement(D4355) is included in the fee for other periodontal procedures and is not payable separately.
 - c) Note that periodontal maintenance(D4910), Procedure Codes that include periodontal maintenance and full mouth debridement(D4355) are covered as a Basic Benefit, and routine cleanings(D1110, D1120) including scaling in presence of generalized moderate or severe gingival inflammation(D4346) are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance(D4910) is only covered when performed following active periodontal therapy(D4260, D4261, D4341, D4342).
 - d) Caries risk assessments(D0601, D0601, D0603) are allowed once in 12 months.
 - e) Interim caries arresting medicament applications(D1354) are covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.
- (4) X-ray limitations:
- a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series(D0210) when the fees for any combination of intraoral x-rays(D0220 – D0240) in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film(D0330) is submitted with supplemental film(s)(D0220, D0230, D0270-D0274, D0277), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series(D0210).
 - c) If a panoramic film(D0330) is taken in conjunction with an intraoral complete series (D0210), Delta Dental considers the panoramic film to be included in the complete series.
 - d) Intraoral - periapical radiographic images(D0220, D0230) are limited to a maximum of 20 in any 12 month period. Intraoral - occlusal radiographic images(D0240) are limited to two (2) in any six (6) month period.
 - e) A complete intraoral series(D0210) and panoramic film(D0330) are each limited to once every 36 months per provider. Additional panoramic films may be allowed when documented as essential for a follow-up/post-operative exam (such as after oral surgery).
 - f) Bitewing x-rays, single radiographic image(D0270) is limited to once per date of service. Bitewing - two or more radiographic images(D0272 – D0277), are limited to once every six (6) months per provider. Bitewing - four radiographic images(D0274) are limited to Enrollees age 10 and older. Bitewings – two or more radiographic images are not billable to the Enrollee or Delta Dental within six (6) months of a full mouth series unless warranted by special circumstances.
 - g) Image capture procedures are not separately allowable services.
- (5) Cephalometric x-rays(D0340) and tomographic surveys(D0322) are covered twice (2) in any 12 month period per provider. Diagnostic casts(D0470) are covered only for the evaluation of Orthodontic Services and are provided once per provider unless special circumstances are documented (such as trauma or

pathology which has affected the course of orthodontic treatment). See Orthodontic Limitations as age limits may apply. 3D x-rays(D0351) are covered once per date of service.

- (6) The fee for pulp vitality tests(D0460) is included in the fees for diagnostic(covered codes only between D0100 – D0999), restorative(covered codes only between D2000 – 2999), endodontic(covered codes only between 3000 – D3999) and emergency procedures(D9110) and is not payable separately.
- (7) Topical application of fluoride solutions(D1206,D1208) is limited to once in a six (6) month period.
- (8) Space maintainer limitations(D1510 – D1575):
 - a) Except for distal shoe space maintainers(D1575), space maintainers(D1510,D1520) are limited to Enrollees through age 17 and covered once per quadrant in a lifetime, except bilateral space maintainers(D1516, D1517, D1526, D1527) which are covered once per arch.
 - b) Distal shoe space maintainer - fixed – unilateral(D1575) is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
 - c) Recementation of space maintainer(D1551, D1552, D1553) is limited to once per provider per applicable arch or quadrant.
 - d) The removal of a fixed space maintainer(D1556, D1557, D1558) is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- (9) Sealants(D1351) are limited as follows:
 - a) once per tooth per provider every 36 months and only to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
 - b) repair(D1353) or replacement(D1351) of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement by the original provider.
- (10) Delta Dental will not cover replacement of an amalgam(D2140 –D2161), prefabricated crown(D2929 – D2934) or resin-based composite restorations (fillings)(D2330 –D2394) within 12 months of treatment for primary teeth or 36 months of treatment for permanent teeth. Replacement restorations within 12 months for primary teeth and within 24 months for permanent teeth are included in the fee for the original restoration.
- (11) Protective restorations (sedative fillings)(D2940) are allowed once per tooth per provider in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.
- (12) Therapeutic pulpotomy(D3220) is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment(D9110) is made when performed on permanent teeth.
- (13) Pulpal therapy (resorbable filling)(D3230, D3240) for anterior primary teeth and pulpal debridement for primary and permanent teeth(D3221) are limited to once per tooth per lifetime. Retreatment of root canal therapy(D3346 – D3348) by the same Provider/Provider office within 12 months is considered part of the original procedure.
- (14) Apexification(D3351 – D3352) is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth with the fee for the final visit included in the fee for the final root canal.
- (15) Retreatment of apical surgery(D3410, D3421,D3425, D3426, D3430) by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (16) Pin retention(D2951) is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
- (17) Palliative treatment(D9110) is allowed once per date of service per provider regardless of the number of teeth and/or areas treated, and the fee for palliative treatment provided in conjunction with any

procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

- (18) Periodontal limitations(covered codes only between D4000 – D4999):
- a) Benefits for periodontal scaling and root planing(D4341, D4342) in the same quadrant are limited to once in every 24-month period for Enrollees age 13 and older.
 - b) Periodontal surgery(covered codes only between D4210 – D4265) in the same quadrant is limited to once in every 36-month period for Enrollees age 13 and older and includes any surgical re-entry or scaling and root planing(D4341, D4342) performed within 36-months by the same dentist/dental office.
 - c) Periodontal services, including covered graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions(D7111, D7140,D7210, D7220, D7230, D7240, D7241, D7250), periradicular surgery (covered codes only between D3410-D3430), ridge augmentation(D7340, D7350, D7950-D7952) or implants (covered codes only between D6010-D6050).
 - d) Periodontal surgery(covered codes only between D4210 – D4265) is subject to a 30 day wait following periodontal scaling and root planing(D4341, D4342) in the same quadrant.
 - e) Cleanings (regular and periodontal)(D1110, D1120,D4346, D4910) and full mouth debridement D4355 are subject to a 30 day wait following periodontal scaling and root planing(D4341, D4342) if performed by the same Provider office.
 - f) When implant procedures(covered codes only between D6000 – D6199) are a covered benefit, 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(D6081) is covered as a basic benefit and are limited to once in a 24-month period.
- (19) Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth(D7270) are covered once per arch regardless of number of teeth involved for permanent, anterior teeth only.
- (20) Surgical repositioning(D7290) of teeth and transseptal fiberotomy/supra crestal fiberotomy (D7291), by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.
- (21) Vestibuloplasty - ridge extension (secondary epithelialization)(D7340) is covered once per arch in a five (5) year period. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)(D7350) is covered once per arch in a lifetime.
- (22) Removal of lateral exostosis (maxilla or mandible)(D7471) and of torus madibularis(D7473), as well as the surgical reduction of osseous tuberosity(D7485), are limited to once per quadrant per lifetime. Removal of torus palatinus(D7472) is limited to once per lifetime.
- (23) Incision and drainage of abscess – intraoral soft tissue(D7510, D7511) is limited to one (1) per quadrant on the same date of service.
- (24) Partial ostectomy/sequestrectomy for removal of non-vital bone(D7550) is limited to on (1) per quadrant on the same date of service.
- (25) Palatal lift prosthesis modification(D5959) and speech aid prosthesis modification(D5960) are limited to twice in a 12 month period.
- (26) Crowns(covered codes D2710 – D2794), excluding prefabricated crowns (covered codes only between D2929 – D2934), are limited to Enrollees age 13 and older and are covered not more often than once in a five (5) year period except when Delta Dental determines the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
- (27) Post and core services(covered codes only between D2952 - D2957) are covered once per tooth in a lifetime on permanent teeth.

- (28) Crown repairs(D2980) are are not a benefit within 12 months of initial crown placement or previous repair for the same provider.
- (29) When allowed within six (6) months of a restoration(D2140-D2161, D2330-D2335, D2391-D2394), the Benefit for a Crown, Inlay/Onlay(covered codes only between D2510 – D2794) or fixed prosthodontic service(covered codes only between D6200- D6999) will be reduced by the Benefit paid for the restoration.
- (30) Removable Denture Repairs(D5511, D5512, D5611, D5612, D5621, D5622) are covered once per arch per date of service per provider and not more than twice in any twelve (12) month period per provider. Adding teeth to an existing partial denture (D5650) is covered once per tooth and is limited to a maximum of three (3) per date of service per provider.
- (31) Implant services(covered codes only between D6000 – D6199) are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Delta Dental for medical necessity for prior authorization. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. 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 prostheses.
 - b) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
 - c) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
 - d) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
- (32) Fixed partial dentures (bridgework) (D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6784, D6791, D6930, D6980, D6999) are not generally covered but shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture(covered codes only between D5211 – D5283). The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60 month period and only for Enrollees age 13 and older.
- Medical conditions, which preclude the use of a removable partial denture, include:
- a) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
 - b) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
 - c) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.
- (33) Prosthodontics(D5110, D5120, D5211 – D5224, D5863 – D5866) (covered codes only between D6211 – D6791) that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Immediate dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance(D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791) and/or implant supported prosthesis(D6058-D6077, D6094, D6110-D6117) not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.
- (34) When a posterior fixed bridge(covered codes only between D6205 – D6794) and a removable partial denture(D5211 – D5283) are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- (35) Recementation of Crowns, Inlays/Onlays or bridges(D2910, D2915, D2920, D6930) is included in the fee for the Crown, Inlay/Onlay or bridge(covered codes only between D2510 – D2794, D6205 – D6974) when

performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12 month period by the same Provider/Provider office.

- (36) The initial installation of a prosthodontic appliance(covered codes only between D5000 – D5899, D6100 – D6999) and/or implants(covered codes only between D6000 D6199) and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.
- (37) TMJ dysfunction procedures are limited to differential diagnosis(covered codes only between D0310- D0322) and symptomatic care(covered codes only between D7810-D7899). Not included as a benefit are those TMJ treatment modalities that involve prosthodontia(D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791), orthodontia(covered codes only between D8000 – D8999) and full or partial occlusal rehabilitation.
- (38) Occlusion analysis – mounted case(D9950), and occlusal adjustments, limited(D9951) and complete(D9952), are limited to one (1) in 12 months for diagnosed TMJ dysfunction for permanent dentition and only for Enrollees age 13 and older.
- (39) Application of desensitizing medicament(D9951) is limited to once in a 12 month period for permanent teeth only.
- (40) Delta Dental limits payment for dentures(covered codes only between D5000 – D5899) to a standard partial(covered codes only between D5211 – D5283) or complete denture(D5110 – D5140) (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments(D5410 – D5422) for the first six (6) months after placement and relines(D5730 – D5761) for the first 12 months after placement.
 - a) Dentures, removable partial dentures(D5211 – D5283) and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment, adjustments are limited to twice in a 12 month period per provider and relining is limited to once in a 12 month period.
 - b) Tissue conditioning(D5850, D5851) is limited to two (2) per prosthesis in a 36 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.
 - c) Recementation of fixed partial dentures(D6930) is not a benefit within 12 months of a previous recementation by the same provider.
- (41) Limitations on Orthodontic Services(covered codes only between D8000 – D8999):
 - a) Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
 - b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
 - c) The automatic qualifying conditions are:
 - i) 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,
 - ii) Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - iii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - iv) A crossbite of individual anterior teeth causing destruction of soft tissue,
 - v) An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
 - vi) Severe traumatic deviation.

- d) The following documentation must be submitted with the request for prior authorization of services by the Provider:
 - i) ADA 2006 or newer Claim Form with service code(s) requested;
 - ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
 - iii) Cephalometric radiographic image or panoramic radiographic image;
 - iv) HLD score sheet completed and signed by the Orthodontist; and
 - v) Treatment plan.
- e) The allowances for comprehensive orthodontic treatment procedures (D8080) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention) (D8680). No additional charge to the Enrollee is permitted.
- f) Comprehensive orthodontic treatment(D8080) includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
- g) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
- h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- j) Pre-orthodontic treatment visits(D8660) are allowed once every three (3) months up to a maximum of six (6) per Enrollee.
- k) Removable and fixed appliance therapy(D8210,D8220) are allowed once per Enrollee age six (6) to 12.
- l) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided (Covered codes only between D8000-D8999), Delta Dental will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
- m) Repair of an orthodontic appliance(D8696, D8697) inserted under this dental plan is covered once per appliance. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch.
- n) Replacement of a lost or broken retainer(D8703, D8704) is a benefit once per arch and only within 24 months following date of service of orthodontic retention.
- o) The removal of fixed orthodontics appliances(D8695) for reasons other than completion of treatment is not a covered benefit.

Exclusions for Pediatric Benefits (under age 19)

Delta Dental does not pay Benefits for:

- (1) services that are not Essential Health Benefits except as required by state or federal law.
- (2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (3) cosmetic surgery or procedures for purely cosmetic reasons(D9972-D9975, D2960-D2962), (exclude covered codes in this list if done for purely cosmetic reasons: D2710–D2751, D2940, D2330–D2394, D8000-D8999).
- (4) provisional and/or temporary restorations(D2799). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

- (6) treatment to stabilize teeth(D7272), treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: periodontal splinting(D4322, D4323) or fixed bridge procedures(D6252–D6720).
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) pain killers or experimental/investigational procedures.
- (9) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia(D9215) and regional/or trigeminal bloc anesthesia(D9211/D9212) are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues)(D4263, D4264).
- (11) laboratory processed crowns for Enrollees under age 13(D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791).
- (12) interim implants(D6012, D6051, D6118, D6119) and endodontic endosseous implants (D3460).
- (13) indirectly fabricated resin-based Inlays/Onlays(D2650 - D2664).
- (14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (16) charges incurred for oral hygiene instruction(D1330), a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling(D1320) or broken appointments(D9986) are not separately payable procedures.
- (17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (20) Deductibles and/or any service not covered under the dental plan.
- (21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (22) the initial placement of any prosthodontic appliance(D5000 – D5899, D6200 – D6999) or implant(D6000 – D6199), unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Delta Dental.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- (23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained(D8000-D8999).
- (24) missed(D9986) and/or cancelled(D9987) appointments.
- (25) action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (26) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

- (27) dental case management motivational interviewing and patient education to improve oral health literacy.
- (28) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (29) diabetes testing.
- (30) corticotomy (specialized oral surgery procedures associated with orthodontics)(D7296, D7297).
- (31) Antigen or antibody testing.

Attachment C
Information Concerning Benefits for Delta Dental Individual & Family™

Delta Dental PPO™
Family Dental PPO

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

ADULTS (AGE 19 AND OLDER)				
	Delta Dental PPO Providers ²	Delta Dental Premier® and Non-Delta Dental Providers ²		
(A) Deductibles ¹ per Enrollee per Family	\$50 each Calendar Year None	\$50 each Calendar Year None		
(B) Lifetime Maximum per Enrollee	\$1,500 each Calendar Year			
(C) Annual Out-of-Pocket Maximum	None			
(D) Professional Services	Policy Benefit Levels			
Dental Service Category:				
Delta Dental will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for the following services:				
Diagnostic and Preventive Services			100%	90%
Basic Services			80%	70%
Major Services ³			50%	50%
Medically Necessary Orthodontic Services	Not a covered benefit	Not a covered benefit		
(E) Outpatient Services	Not Covered			
(F) Hospitalization Services	Not Covered			
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.			
(H) Ambulance Services	Not Covered			
(I) Prescription Drug Coverage	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			

¹ The annual Deductible is waived for Diagnostic and Preventive Services.

² Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

³ Major Services are limited to Adult Enrollees who have been enrolled in the Policy for six consecutive months. The six month Waiting Period for Major Services must be waived upon Enrollee's proof of prior comparable dental coverage. This Waiting Period shall be prorated on a one to one monthly basis upon Enrollee's proof of prior comparable dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month Waiting Period would no longer occur. Dental services

obtained via a discount health plan are not considered “comparable” dental coverage for purposes of counting towards the Waiting Period.

PEDIATRIC (UNDER AGE 19)				
	Delta Dental PPO Providers ²	Delta Dental Premier and Non-Delta Dental Providers ²		
(A) Deductibles ¹ per Enrollee per Family	\$75 each Calendar Year \$150 each Calendar Year	\$75 each Calendar Year \$150 each Calendar Year		
(B) Lifetime Maximums per Enrollee	None	None		
(C) Annual Out-of-Pocket Maximum* Pediatric Enrollee Multiple Pediatric Enrollees	\$350 each Calendar Year \$700 each Calendar Year	None None		
(D) Professional Services	Policy Benefit Levels			
Dental Service Category:				
Delta Dental will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for the following services:				
Diagnostic and Preventive Services			100%	90%
Basic Services			80%	70%
Major Services			50%	50%
Medically Necessary Orthodontic Services			50%	50%
(E) Outpatient Services	Not Covered			
(F) Hospitalization Services	Not Covered			
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee’s condition and/or provide palliative relief.			
(H) Ambulance Services	Not Covered			
(I) Prescription Drug Coverage	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			

¹ The annual Deductible is waived for Diagnostic and Preventive Services.

² Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

* Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by Delta Dental PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollee(s) equals the Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services received from Delta Dental PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services received from Premier and Non-Delta Dental Providers even after the Out-of-Pocket Maximum is met.

If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from Delta Dental PPO Providers is not more than the multiple Pediatric Enrollees Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have

satisfied their Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from Delta Dental PPO Providers until the total amount paid reaches the Out-of-Pocket Maximum for multiple Pediatric Enrollees.

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 888-282-8978 (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 888-282-8978 (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 888-282-8978 (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 888-282-8978 (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 888-282-8978 (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 888-282-8978 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ զրկած ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 888-282-8978 (TTY 711): (Armenian)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 888-282-8978 (TTY: 711). (Persian Farsi)

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 888-282-8978 (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 888-282-8978 (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 888-282-8978 (TTY: 711)। (Hindi)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、888-282-8978 (TTY: 711) までお問い合わせください。 (Japanese)

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। ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 888-282-8978 (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 888-282-8978 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសាបស្ចិមលោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 888-282-8978 (TTY: 711)។ (Cambodian)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย ได้รับความช่วยเหลือฟรีได้โดยโทรไปที่ 888-282-8978 (TTY: 711) (Thai)

Service Areas

Coverage is available in the following counties in California:

Full counties (plan available anywhere in the county):

Alameda
Alpine
Amador
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Kings
Lake
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Monterey
Napa
Nevada
Orange

Placer
Plumas
Sacramento
San Benito
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Solano
Sonoma
Stanislaus
Sutter
Trinity
Tulare
Ventura
Yolo
Yuba

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

Imperial
Inyo
Kern
Lassen
Modoc
Mono
Riverside
San Bernardino
Siskiyou
Tehama
Tuolumne