DeltaCare® USA

Delta Dental Individual & Family™
DeltaCare® USA
Basic Plan for Families

This Is a Limited Policy – Read it Carefully

Policy/Disclosure Form ("Policy")

Provided by:
Delta Dental of Pennsylvania
300 Corporate Center Drive
Camp Hill, PA 17011-1744
888-857-0337

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023-1803
888-857-0337

You must make an election on the Exchange for any eligible person You wish to cover under this Policy. If an election is not made on the Exchange for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten by Delta Dental of Pennsylvania ("Delta Dental") and administered by Delta Dental Insurance Company ("Administrator"). This Policy discloses the terms and conditions of the individual DeltaCare® USA dental plan available in Pennsylvania. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application through the Exchange. It takes effect on the Effective Date shown in the Policy Information attachment included with this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIST SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

Notice of Insured's Right to Return this Policy

You will be permitted to return this Policy within ten (10) days of its delivery and to have the Premium paid refunded if after examination of this Policy, You are not satisfied with it for any reason. You will return this Policy to Delta Dental or to the agent through whom it was purchased. It will be void from the beginning and the parties will be in the same position as if no Policy had been issued.

In the absence of fraud, all statements made by any Enrollee or the policyholder or by an insured person will be deemed representations and not warranties. No statement made for the purpose of effecting insurance will avoid such insurance or reduce Benefits, unless contained in a written instrument signed by the Enrollee and a copy has been furnished to the Enrollee.

This Policy is signed for Delta Dental of Pennsylvania, as of its Effective Date by:

Michael G. Hankinson, Esq.
Executive Vice President, Chief Legal and Compliance Officer

This Policy is renewable at the option of the insured.

This Policy contains Renewal and Termination of Coverage provisions.
Please read them carefully. This is a non-participating Policy.

deltadentalins.com
https://pennie.com
844-844-8040

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INTRODUCTION

We are pleased to welcome You to this individual DeltaCare USA dental plan. Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to see the Dentist, but to see them on a regular basis.

Eligibility under this Policy is determined by the Exchange. This Policy provides dental Benefits for children and adults as defined in the following sections:

- **Eligibility Requirement for Pediatric Benefits (Essential Health Benefits)**
- **Eligibility Requirement for Adult Benefits**

Using This Policy

This Policy discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "You" and "Your" mean the Enrollees who are covered under this Policy. "We," "Us" and "Our" always refer to Delta Dental or the Administrator.

Contact Us

If You have any questions about Your coverage that are not answered here, please visit Our website at deltadentalins.com or call Our Customer Service Center at 888-857-0337.

If You prefer to write to Us with Your question(s), please mail Your inquiry to the following address:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023-1803

Identification Number

Please provide the Enrollee's identification ("ID") number to Your Dentist whenever You receive dental services. ID cards are not required. If You wish to have an ID card, You may obtain one by visiting Our website at deltadentalins.com.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the Commonwealth of Pennsylvania. Certain functions described throughout this Policy may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023-1803. The Administrator will answer calls directed to 888-857-0337.

Adult Benefits: dental services under this Policy for people age 19 years and older.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits: covered dental services provided under the terms of this Policy.

Calendar Year: the 12 months of the year from January 1 through December 31.

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan. Referrals for Specialist Services must be obtained from Your Contract Dentist.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

Dentist: a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Effective Date: the original date the plan starts.

Eligible Dependent: a person who is a dependent of an Eligible Primary and considered to be a Qualified Individual by the Exchange. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Pediatric Individual: a person who is considered to be a Qualified Individual by the Exchange. Eligible Pediatric Individuals are eligible for Pediatric Benefits as described in this Policy.

Eligible Primary: a person who is considered to be a Qualified Individual by the Exchange. Eligible Primaries are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Emergency Services: only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee: an Eligible Primary ("Primary Enrollee"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Individual ("Pediatric Enrollee") enrolled under this Policy to receive Benefits; persons eligible and enrolled under this Policy for Adult Benefits may also be referred to as "Adult Enrollees."

Essential Health Benefits ("Pediatric Benefits"): for the purposes of this Policy, Essential Health Benefits are certain pediatric oral services that are required to be included in this Policy under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.

Exchange: the Pennsylvania Health Benefit Exchange ("Pennie").

Open Enrollment Period: the period of the year that the Exchange has established when the Primary Enrollee may change coverage selections for the next Policy Year.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions of this Policy.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Us to provide Benefits under the terms of this Policy.

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for Benefits during the Calendar Year. Refer to Schedule A attached to this Policy for details.

Policy: this agreement between Delta Dental and the Primary Enrollee including any application supplied by the Exchange and any attachments. This Policy constitutes the entire agreement between the parties.

Policy Year: the 12 months starting on January 1st and each subsequent 12-month period thereafter. Policy Year can be less than 12 months if You have an Effective Date mid-year due to a Qualifying Status Change or other exceptional circumstance as determined by the Exchange.

Policyholder: the Primary Enrollee who enrolls for coverage. If this Policy is offered as a child-only or multi-child only Policy by the Exchange, a Primary Enrollee can be an Eligible Pediatric Individual enrolled for coverage by a responsible party, who assumes all responsibilities as a Policyholder. Responsible parties may include: parent, step-parent, adoptive parent, foster parent or Spouse of the Eligible Pediatric Individual.

Premium: the amount payable as provided in the Policy Information attachment included with this Policy.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association®.

Qualified Individual: an individual determined by the Exchange to be eligible to enroll through the Exchange.

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (You move);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Enrollment Period: a time the Exchange has established outside the yearly Open Enrollment Period when You can sign-up for coverage.

Specialist Services: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Spouse: a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides.

Teledentistry: the delivery of dental services through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

Waiting Period: the amount of time an Enrollee must be enrolled under this Policy for specific services to be covered.

ELIGIBILITY AND ENROLLMENT

The Exchange is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported by the Exchange.

This Policy includes Pediatric Benefits and Adult Benefits. Enrollees are eligible for either Pediatric or Adult Benefits according to the requirements listed below:

Eligibility Requirement for Pediatric Benefits

Pediatric Enrollees are Qualified Individuals as determined by the Exchange who are eligible and have enrolled for Pediatric Benefits under this Policy. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor to age 19; and/or
- a Primary Enrollee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

Eligibility Requirement for Adult Benefits

Primary Enrollees and Dependent Enrollees are Qualified Individuals as determined by the Exchange who are eligible and have enrolled for Adult Benefits under this Policy. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee age 19 years of age or older; and/or
- a Primary Enrollee's Spouse age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

A dependent unmarried child 26 years of age or older may continue eligibility for Adult Benefits if:

- they are incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- they are chiefly dependent on the Primary Enrollee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical disability that began before they reached the limiting age.

Renewal

This Policy remains in effect for the Policy Year, provided it is not terminated by Us or by the Primary Enrollee. The Primary Enrollee will receive renewal information from the Exchange prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the Exchange during the Open Enrollment Period. Provided Delta Dental continues to make this Policy available through the Exchange at the renewal period:

- the Primary Enrollee may elect to choose this Policy, subject to the applicable Premium through the Exchange for this plan at the time of renewal; or
- the Primary Enrollee may not have to make an election through the Exchange in subsequent Open Enrollment Periods to continue coverage. You should refer to the Exchange rules regarding automatic renewal of coverage.

Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Policy by contacting Pennie. The effective date of a termination will be the date reported by the Exchange. If coverage is terminated because You are covered by Medicaid, the last day of coverage with Us is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of its delivery.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, We may terminate coverage due to:

- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits; or
- We cease to renew all Policies issued on this form to residents of the state where You live.

If termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies You of lack of eligibility. If You are no longer eligible due to age, termination is effective on the date reported by the Exchange and You should contact the Exchange to see if Special Enrollment Periods apply.

If Your coverage is terminated, We will send a written notice to You informing You of the reasons(s) why coverage is terminated and the date that Your coverage will end. For treatment in progress, We will continue to provide Benefits less any applicable Copayment.

Reinstatement

If any renewal Premium is not paid in full within the time granted the subscriber for payment, a later acceptance of Premium in full by Delta Dental or by any agent authorized by Delta Dental to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the Premium in full, will reinstate the Policy. However, if Delta Dental or the agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of the application by Delta Dental or, lacking approval, upon the forty-fifth day following the date of the conditional receipt unless We have previously notified the subscriber in writing of its disapproval of the reinstatement application.

The reinstated Policy will cover only loss resulting from accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than ten (10) days after the date of reinstatement. In all other respects the subscriber and Delta Dental will have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on the Policy or attached to the Policy in connection with the reinstatement. Any Premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. If the date of Policy termination was more than sixty (60) days prior to the date of reinstatement, You must complete new enrollment forms and pay the enrollment fee as well as the annual premium.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give You a better understanding of how the dental plan works and how to make it work best for You .

What is the DeltaCare USA Plan?

The DeltaCare USA plan provides Pediatric and Adult Benefits through a convenient network of Contract Dentists in the Commonwealth of Pennsylvania. These Dentists are screened to ensure that Our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When You visit Your assigned Contract Dentist, You pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Policy. Benefits are only available in the Commonwealth of Pennsylvania. The services are performed as deemed appropriate by Your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Policy. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Policy.

In the event that We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services. For further clarification, see *"Emergency Services"* and *"Specialist Services."*

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST

Delta Dental will provide Contract Dentists at convenient locations during the term of this Policy. Upon enrollment, We will assign the Enrollees to one Contract Dentist facility. The Policyholder may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 888-857-0337. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

We will provide You written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that You be re-assigned to another facility.

All treatment in progress must be completed before You change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; and 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility assigned to You. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by Your Contract Dentist. We will have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist, and authorized by Us. All authorized Specialist Services claims will be paid by Us less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If Your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all treatment in progress as described above.

Emergency Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, You should contact the Contract Dentist facility whenever possible. If You are unable to reach the Contract Dentist facility for Emergency Services, You should call the Customer Service Center at 888-857-0337 for assistance in obtaining urgent care. During non-business hours or if You require Emergency Services and are 35 miles or more from Your assigned Contract Dentist facility, You do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized by Us. You pay the specified Copayment. (Refer to the Schedules attached to this Policy.)

If You require Specialist Services and there is no Contract Orthodontist or Contract Specialist to provide these services within 35 miles of Your home address, the assigned Contract Dentist must receive Authorization from Delta Dental to refer You to an Out-of-Network orthodontist or Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network orthodontist or Out-of-Network specialist that are not authorized by Delta Dental will not be covered.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Policy to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services should be sent to Us within 90 days of *the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not* reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810.

Processing Policies

The dental care guidelines for the DeltaCare USA plan explain to Contract Dentists what services are covered under this Policy. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for You. Services performed by the Contract Dentists, Contract Orthodontists and Contract Specialists that fall under the scope of Benefits of this Policy are provided subject to any Copayments. If a Contract Dentist believes that You should seek treatment from a specialist, the Contract Dentist contacts Us for a determination of whether the proposed treatment is a covered Benefit. We will also determine whether the proposed treatment requires treatment by a specialist. You may contact Delta Dental's Customer Service Center at 888-857-0337 for information regarding the dental care guidelines for DeltaCare USA.

Notice of Claim

In the case of Emergency or Specialist Services, written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810, or to any other authorized agent of the insurer, with information sufficient to identify the insurer, will be deemed notice to the insurer.

Claim Forms

The Administrator, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss

Claims for covered Emergency Dental Services or preauthorized Specialist Services should be sent to Us within 90 days of the end of treatment. Valid claims will be reviewed after 90 days if You can show that it was not reasonably possible to submit the claim within that time. Late claims must be submitted as soon as possible. All claims must be received within one year of the treatment date except in the absence of legal capacity of the claimant.

Time of Payment of Claims

Indemnities payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity will be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of Delta Dental, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

ENROLLEE COMPLAINT PROCEDURE

Delta Dental will address all Enrollee inquiries, complaints and grievances promptly and professionally. Written records will be maintained classifying such Enrollee contacts by type (i.e. inquiry, complaint or grievance) in a written log. We will routinely advise You of Your rights under the complaint/grievance system over the telephone and on all claims and other correspondence which refer to Benefits which have been denied.

Definitions

Inquiry: An inquiry is any Enrollee's request for administrative service, or information, or to express an opinion. Whenever specific corrective action is requested by You, or determined to be necessary by Us, it should be classified as a complaint.

Complaint: A complaint is an issue You present to Us, either in written or oral form, which is subject to informal resolution by Us within a 30 day period. A written log of each complaint and its disposition is maintained. Failure to render a decision within the 30 day timeframe automatically results in the complaint being upgraded to a grievance.

Grievance: A grievance is a complaint which cannot be resolved to Your satisfaction or when the Enrollee requests formal grievance consideration during the 30 day period. All grievances will be committed to written form by either the Enrollee or Delta Dental prior to processing.

We will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, You may call the Customer Service Center at 888-857-0337, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023-1860

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and identification number of the Primary Enrollee; and 3) the Dentist's name and facility location.

A systematic progression of appeals will be in place. If the initial decision is appealed and informal resolution has not been possible, it will be addressed by the 1st Level Grievance Committee. If the 1st Level Grievance Committee's decision is appealed, that appeal will be addressed by the 2nd Level Grievance Committee. If the 2nd Level Grievance Committee's decision is appealed, that appeal will be addressed by the Pennsylvania Department of Health.

At each step, if the decision is not in favor of the Enrollee, the Enrollee will be advised (1) of the right to appeal the decision and (2) of how to use the appeal process.

1st Level Grievance Review Committee

Appeals will first be addressed by the 1st Level Grievance Review Committee. The committee is made up of one or more Delta Dental employees. The committee will not include any person whose decision is being appealed or who made the initial determination denying claim or handling a complaint. This first level review may be in the form of a telephone conference, staff meeting or polling of experts by telephone.

You have the right to submit written material and to have an uninvolved staff person assist, but You do not have the right to attend or to have representation in attendance at this stage. We will advise You of Your rights.

The review will be conducted within 30 days of receipt of the appeal. The decision of the 1st Grievance Review Committee will be made known to the Enrollee in writing at the earliest possible time following the review but not more than five working days after the date of the review.

Written decision will contain:

1) description of the committee's understanding of Your grievance as presented to the grievance committee, e.g. dollar amount of the disputed issue, medical facts in dispute, etc.;

2) committee's decision in clear terms and the contract basis or medical rationale in sufficient detail for You to respond further to Delta Dental's position, e.g. did not contact primary care physician, nonemergency service as identified in dental records, or not covered by group contract;

3) evidence or documentation used as the basis for the decision should be referenced in the letter, e.g. specific provisions, group contract, dental records, etc.; and

4) statement indicating:

a) decision is binding unless the Enrollee appeals to the second level;

b) a description of the process on exactly how to appeal to the 2nd Level Grievance Review Committee; and

c) the written procedures governing appeal including the required timeframe of 35 days from the date of the letter for appeal.

2nd Level Grievance Review Committee

Delta Dental's 2nd Level Grievance Committee will be made up of three (3) members. In agreement with the Pennsylvania HMO Act and the Department of Health Regulations, the members will be selected by the Board of Directors and one-third of the members will be actual Delta Dental Enrollees. A Delta Dental Enrollee will be selected when needed to serve on a Grievance Review Committee. The subscriber member will be selected from among the Delta Dental employer and union groups' benefits administrators who are also Delta Dental Enrollees.

This committee may not include any person previously involved in the grievance. Committee members must have the ability to be fair and impartial. A continuity of the Grievance Committee Membership is necessary so as to facilitate a knowledgeable and consistent approach to grievance resolution. It is imperative that the committee carefully consider and make particular findings of fact on all key factual disputes.

Provisions Regarding Enrollee Rights

1) You always have a right to attend the 2nd level hearing and to present Your case and have the right to be assisted/represented by a person of Your choice. The hearing will be held in Pennsylvania or in another location convenient to You .

2) You may again submit written material in support of his claim. Formal rules of evidence are not appropriate, and the Enrollee may arrange for a physician or other expert to testify on his behalf.

3) You have the right to question Delta Dental staff concerning the dispute.

4) Your right to a fair and equitable hearing may not be made conditional on their appearance at the hearing. Regardless of Your presence or lack of, the hearing must be conducted in the same manner.

5) Delta Dental is responsible for insuring that hearings are held at mutually convenient times. You will be notified in writing, at least 15 days in advance, of the date and time of the hearing, which should be held within 30 days of receipt of the appeal. Requests for hearing postponement by You (for just cause) must be considered.

6) You will receive a description of the Committee's procedures so as to permit You to be prepared for the hearing.

7) You should also be re-advised of Your right to have a non-involved staff person to assist You in preparing for the grievance hearing.

Provisions Regarding the Hearing Process

1) The written decision of the 1st Level Grievance Committee will be the basis for deliberation. The objective is to keep the hearing informal and impartial so as not be intimidating to the Enrollee.

2) Matters brought before the Grievance Committee should not be discussed by the Committee prior to the meeting.

3) Committee members should be introduced to the Delta Dental Enrollee filing the appeal, and there should be clear identification of the subscriber member and Delta Dental staff serving on the Committee.

4) There should be a clear recognition on the part of all members of the Committee, subscriber members and Delta Dental staff alike, that their responsibility is to impartially hear and consider the dispute based solely on the material and presentations made during the hearing.

5) If an attorney representing Delta Dental is present at the hearing, the primary purpose of the attorney should be to represent the interest of the impartial Grievance Review Committee in insuring that a fundamentally fair hearing takes place and all issues in dispute are adequately addressed. The attorney should not argue or represent Delta Dental staff position in the dispute.

6) If Delta Dental desires to have an attorney present to represent the interests of the Delta Dental staff, it also must make available an attorney to represent and assist the Grievance Committee.

7) The 2nd level hearing will be tape recorded. Written summary minutes will be prepared from this tape. A written transcript will be prepared for all hearings involving cases in excess of $5,000.00.

8) A member of the Delta Dental staff previously involved in and knowledgeable about the grievance should present and summarize for the Committee, the Delta Dental staff's rationale for recommending that the denial be affirmed by the 2nd Level Grievance Committee.

9) The Committee should be permitted to ask questions of the Delta Dental staff.

10) The Delta Dental Enrollee or his/her representative should be given the right to present his/her side of the dispute and ask questions of the Delta Dental person(s) presenting the Delta Dental side of the dispute.

11) The Committee must render a decision no more than 10 working days following the Grievance Committee meeting.

12) The Enrollee must be advised, in writing, of the outcome of the Committee's deliberation. The written notice shall contain:

    a) a statement of the Committee's understanding of the nature of the grievance and of all pertinent facts;

    b) the Committee's decision and rationale;

    c) evidence or documentation supporting such conclusions; and

    d) a statement of the Enrollee's right to appeal to the Department of Health with the phone number and complete address of the Department. The address and phone number to be used is:

    Bureau of Health Financing and Program Development
    Pennsylvania Department of Health
    Room 1026 Health & Welfare Building
    P. O. Box 90
    Harrisburg, PA 17108-0090
    Phone: 717-787-5193

Policy Statement for Recording 2nd Level Grievance Review Committee Proceedings

1) All 2nd level grievance procedure meetings will be tape recorded. Upon request of the Pennsylvania Department of Health, a duplicate tape will be sent to the Department.

2) Summary minutes will be used for the purpose of responding to You regarding the decision of the 2nd Level Grievance Committee.

3) Verbatim transcript will be made of all 2nd Level Grievance Committee meetings involving cases in excess of $5,000.00.

Provisions to Expedite Grievances Where There is Alleged Medical Urgency

Grievances usually deal with claim denials, and the remedy sought is payment of the claim by Delta Dental. In those cases, however, where You believe that serious medical consequences will arise in the near future (7 to 10 days) from Delta Dental's failure to provide needed, medically necessary and covered health services, there is a procedure for expedited review.

In such a case, You should identify the particular need for an expedited review to the Customer Service Center. We will arrange to have the grievance reviewed by a dental director within 48 hours and the dental director will inform the Enrollee of their decision in writing.

If the dental director's decision is adverse to You , You may appeal the decision immediately to the 2nd Level Grievance Review Committee.

The Bureau of Health Financing & Program Development in the Pennsylvania Department of Health, Room 1026, Health & Welfare Building, P.O. Box 90, Harrisburg, PA 17108-0090 (717-787-5193) is responsible for monitoring Our compliance with the grievance procedures.

If You believe You need further review of Your claim, You may contact Your state insurance regulatory agency.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy You receive, if applicable. Premiums are listed in the Policy Information attachment included with this Policy. The Primary Enrollee is responsible for making Premium payments.

Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium by visiting Our website at deltadentalins.com, or by mailing payment to the address below:

Delta Dental of Pennsylvania
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new rates in force at the time of Your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or due to other extraordinary circumstance as determined by the Exchange.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting Our website at deltadentalins.com or by contacting Our Customer Service Center toll-free at 888-857-0337.

Grace Period on Late Payments

For Enrollees receiving an Advanced Premium Tax Credit ("APTC"):

- If Your Premium payment is not received by the first of the month, a grace period of three (3) months will be granted. During the grace period, this Policy will continue in force. However, Your coverage for the second and third months of the grace period will be suspended and claims incurred during the second and third months of the grace period will not be paid unless all Premiums due are paid prior to the expiration of the grace period. If Premiums are received during the grace period, then the Enrollees will be reinstated as of the last day of paid coverage. If Premiums are not received prior to the end of the grace period, coverage will be terminated as of the end of the last day of the first month of the grace period.

For Enrollees not receiving an Advanced Premium Tax Credit ("non-APTC"):

- Unless not less than five (5) days prior to the Premium due date We have delivered or mailed to You written notice of ins intention not to renew this Policy beyond the period for which Premium has been accepted, a grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time, this Policy will continue in force. Coverage will terminate at the end of the grace period unless We receive Your Premium before the end of this 31 days.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including any application and attachments, constitutes the entire contract of insurance. No change to this Policy will be valid until approved by Our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Severability

If any part of this Policy or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Policy will remain in full force and effect.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

Physical Examinations and Autopsy

We at Our own expense will have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other charges in this Policy.

Misstatement of Age

If the age of the Enrollee has been misstated, all amounts payable under this Policy will be such as the premium paid would have purchased at the correct age.

Conformity with State Statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, We reserve the right to adjust the Premium to reflect Your actual circumstances at time of application or to terminate Your Policy.

Third Party Administrator ("TPA")

We may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Us providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Impossibility of Performance

Neither party (Policyholder or Us) shall be liable to the other or be deemed to be in breach of this Policy for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

Non-Discrimination

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with Us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If You need these services, contact Our Customer Service Center at 888-857-0337.

If You believe that We have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

DeltaCare USA
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 888-857-0337
Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SCHEDULE A

Description of Benefits and Copayments
Delta Dental Individual & Family™
DeltaCare® USA
Basic Plan for Families

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Pediatric Enrollee	**$425.00** each Calendar Year
Multiple Pediatric Enrollees	**$850.00** each Calendar Year

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

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

We recommend that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If You have any questions regarding Your OOPM, please contact the Customer Service Center at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	$15	$15	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	No cost	No cost		
D0140	Limited oral evaluation - problem focused	No cost	No cost		
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No cost	Not a Benefit		
D0150	Comprehensive oral evaluation - new or established patient	No cost	No cost		
D0160	Detailed and extensive oral evaluation - problem focused, by report	No cost	No cost		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	Not a Benefit	No cost		
D0171	Re-evaluation – post-operative office visit	Not a Benefit	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	No cost	No cost		
D0190	Screening of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral - comprehensive series of radiographic images	$10	$10	*1 of (D0210 or D0330) series per 36 months*	*1 of (D0210 or D0330) series per 24 months*
D0220	Intraoral - periapical first radiographic image	No cost	No cost		
D0230	Intraoral - periapical each additional radiographic image	No cost	No cost		
D0240	Intraoral - occlusal radiographic image	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	Not a Benefit	No cost		
D0270	Bitewing - single radiographic image	No cost	No cost		
D0272	Bitewings - two radiographic images	No cost	No cost		
D0273	Bitewings - three radiographic images	No cost	No cost		
D0274	Bitewings - four radiographic images	No cost	No cost	*1 series per 6 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No cost	$10		
D0330	Panoramic radiographic image	$10	$25	*1 of (D0330 or D0210) per 36 months*	*1 of (D0330 or D0210) series per 24 months*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$10	Not a Benefit		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$10	Not a Benefit		
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No cost	Not a Benefit		
D0415	Collection of microorganisms for culture and sensitivity	Not a Benefit	No cost		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a Benefit	No cost		
D0460	Pulp vitality tests	Not a Benefit	No cost		
D0470	Diagnostic casts	$30	No cost		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image - image capture only	No cost	No cost		
D0702	2D cephalometric radiographic image - image capture only	No cost	Not a Benefit		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No cost	Not a Benefit		
D0706	Intraoral - occlusal radiographic image - image capture only	No cost	No cost		
D0707	Intraoral - periapical radiographic image - image capture only	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0708	Intraoral - bitewing radiographic image - image capture only	No cost	No cost		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a Benefit	$45		*Up to 2 additional cleanings per 12 months*
D1120	Prophylaxis - child	$15	Not a Benefit	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	
D1206	Topical application of fluoride varnish	$10	$5	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride – excluding varnish	$10	$5	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	Not a Benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a Benefit	No cost		
D1330	Oral hygiene instructions	Not a Benefit	No cost		
D1351	Sealant - per tooth	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1354	Application of caries arresting medicament – per tooth	$10	$5	*1 per 6 months*	*2 per 12 months*
D1510	Space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit		
D1516	Space maintainer – fixed – bilateral, maxillary	$195	Not a Benefit		
D1517	Space maintainer – fixed – bilateral, mandibular	$195	Not a Benefit		
D1520	Space maintainer – removable, unilateral – per quadrant	$140	Not a Benefit		
D1526	Space maintainer – removable – bilateral, maxillary	$195	Not a Benefit		
D1527	Space maintainer – removable – bilateral, mandibular	$195	Not a Benefit		
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$30	Not a Benefit		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$30	Not a Benefit		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$30	Not a Benefit		
D1556	Removal of fixed unilateral space maintainer - per quadrant	$15	Not a Benefit		
D1557	Removal of fixed bilateral space maintainer - maxillary	$15	Not a Benefit		
D1558	Removal of fixed bilateral space maintainer - mandibular	$15	Not a Benefit		
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit	*1 per quadrant per lifetime; Age 8 and under*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.					
D2140	Amalgam - one surface, primary or permanent	$45	$40		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2150	Amalgam - two surfaces, primary or permanent	$60	$50		
D2160	Amalgam - three surfaces, primary or permanent	$70	$65		
D2161	Amalgam - four or more surfaces, primary or permanent	$85	$80		
D2330	Resin-based composite - one surface, anterior	$75	$70		
D2331	Resin-based composite - two surfaces, anterior	$90	$85		
D2332	Resin-based composite - three surfaces, anterior	$100	$95		
D2335	Resin-based composite - four or more surfaces (anterior)	$125	$120		
D2390	Resin-based composite crown, anterior	Not a Benefit	$190		
D2391	Resin-based composite - one surface, posterior	Not a Benefit	$75		
D2392	Resin-based composite - two surfaces, posterior	Not a Benefit	$90		
D2393	Resin-based composite - three surfaces, posterior	Not a Benefit	$105		
D2394	Resin-based composite - four or more surfaces, posterior	Not a Benefit	$125		
D2510	Inlay - metallic - one surface	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	$340	$340	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2542	Onlay - metallic - two surfaces	$335	$335	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2544	Onlay - metallic - four or more surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2610	Inlay - porcelain/ceramic - one surface	Not a Benefit	$350		*1 per 60 months*
D2620	Inlay - porcelain/ceramic - two surfaces	Not a Benefit	$385		*1 per 60 months*
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a Benefit	$405		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not a Benefit	$415		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not a Benefit	$415		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a Benefit	$425		*1 per 60 months*
D2650	Inlay - resin-based composite - one surface	Not a Benefit	$250		*1 per 60 months*
D2651	Inlay - resin-based composite - two surfaces	Not a Benefit	$275		*1 per 60 months*
D2652	Inlay - resin-based composite - three or more surfaces	Not a Benefit	$310		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not a Benefit	$305		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not a Benefit	$330		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not a Benefit	$375		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	Not a Benefit	$125		*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	Not a Benefit	$125		*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a Benefit	$425		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	Not a Benefit	$325		*1 per 60 months*
D2722	Crown - resin with noble metal	Not a Benefit	$425		*1 per 60 months*
D2740	Crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2751	Crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2790	Crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2792	Crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2794	Crown - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same dentist/office*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a Benefit	$45		
D2920	Re-cement or re-bond crown	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same dentist/office*	
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a Benefit	$120		*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$200	$200	*1 per 60 months; through age 14*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$200	Not a Benefit	*1 per 60 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$130	Not a Benefit	*1 per 60 months; through age 14*	
D2931	Prefabricated stainless steel crown - permanent tooth	$200	$200	*1 per 60 months; through age 14*	
D2940	Protective restoration	$40	$25		
D2949	Restorative foundation for an indirect restoration	$125	$125		
D2950	Core buildup, including any pins when required	$125	$125	*1 per 60 months*	
D2951	Pin retention - per tooth, in addition to restoration	$30	$30		
D2952	Post and core in addition to crown, indirectly fabricated	Not a Benefit	$185		*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	Not a Benefit	$70		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	$120	$120	*1 per 60 months; includes canal preparation*	*Includes canal preparation*
D2955	Post removal	Not a Benefit	$40		
D2957	Each additional prefabricated post - same tooth	Not a Benefit	$45		*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	Not a Benefit	$400		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	Not a Benefit	$440		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) - indirect	Not a Benefit	$500		*Limited to replacement of significant tooth structure loss due to caries or fracture*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a Benefit	$100		
D2976	Band stabilization – per tooth	$70	$65	*1 per tooth per lifetime*	*once per tooth per lifetime*
D2980	Crown repair necessitated by restorative material failure	$110	$110		
D2981	Inlay repair necessitated by restorative material failure	$110	$110		
D2982	Onlay repair necessitated by restorative material failure	$110	$110		
D2983	Veneer repair necessitated by restorative material failure	$110	$110		
D2989	Excavation of a tooth resulting in the determination of non-restorability	No cost	No cost		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	Not a Benefit	$40		
D3120	Pulp cap - indirect (excluding final restoration)	Not a Benefit	$40		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$80	Not a Benefit		
D3221	Pulpal debridement, primary and permanent teeth	Not a Benefit	$70		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80	Not a Benefit		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; through age 5*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; primary molars through age 11*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$270	$270	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$320	$320	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$390	$390	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$270	$270		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$150	$150		
D3333	Internal root repair of perforation defects	Not a Benefit	$115		
D3346	Retreatment of previous root canal therapy - anterior	$350	$350		
D3347	Retreatment of previous root canal therapy - premolar	$350	$350		
D3348	Retreatment of previous root canal therapy - molar	$350	$350		
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$200	Not a Benefit		
D3352	Apexification/recalcification - interim medication replacement	$200	Not a Benefit		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$300	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3355	Pulpal regeneration - initial visit	$175	Not a Benefit		
D3356	Pulpal regeneration - interim medication replacement	$88	Not a Benefit		
D3357	Pulpal regeneration - completion of treatment	$88	Not a Benefit		
D3410	Apicoectomy - anterior	$280	$280		
D3421	Apicoectomy - premolar (first root)	$290	$290		
D3425	Apicoectomy - molar (first root)	$350	$350		
D3426	Apicoectomy (each additional root)	$150	$150		
D3430	Retrograde filling - per root	Not a Benefit	$120		
D3450	Root amputation - per root	$220	$220		
D3471	Surgical repair of root resorption - anterior	$280	$280		
D3472	Surgical repair of root resorption - premolar	$280	$280		
D3473	Surgical repair of root resorption - molar	$280	$280		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$280	$280		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$280	$280		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$280	$280		
D3911	Intraorifice barrier	No cost	No cost	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3920	Hemisection (including any root removal), not including root canal therapy	$220	$220		
D3921	Decoronation or submergence of an erupted tooth	$85	$85		
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260	$260	*1 per 24 months per quadrant*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$150	$150	*1 per 24 months per quadrant*	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No cost	No cost	*1 per 24 months per quadrant*	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$200	$200	*1 per 24 months per quadrant*	
D4245	Apically positioned flap	Not a Benefit	$135		
D4249	Clinical crown lengthening - hard tissue	$280	$280	*1 per tooth per lifetime*	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$255	$280	*1 per 24 months per quadrant*	
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not a Benefit	$150		
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not a Benefit	$210		
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	Not a Benefit	$240		
D4270	Pedicle soft tissue graft procedure	$350	$350		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350	$350		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a Benefit	$105		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a Benefit	$350		
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$350	$350	*1 per 24 months per quadrant*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$350	$350	*1 per 24 months per quadrant*	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$210	$210		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a Benefit	$210		
D4286	Removal of non-resorbable barrier	Not a Benefit	No Cost		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$110	$110	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$65	$65	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$90	$90	*1 per lifetime*	*1 treatment per 12 months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$100	$100	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	No cost	No cost	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	$60	$60	*4 treatments per 12 months*	*2 per 12 months*
D4910	Periodontal maintenance	Not a Benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a Benefit	$25		
D4921	Gingival irrigation with a medicinal agent – per quadrant	No cost	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments, rebasing and relining, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments, rebasing and relining, if needed, for the first three months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.					
D5110	Complete denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5140	Immediate denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$40	$40		
D5411	Adjust complete denture - mandibular	$40	$40		
D5421	Adjust partial denture - maxillary	$40	$40		
D5422	Adjust partial denture - mandibular	$40	$40		
D5511	Repair broken complete denture base, mandibular	$90	$90		
D5512	Repair broken complete denture base, maxillary	$90	$90		
D5520	Replace missing or broken teeth - complete denture (each tooth)	$90	$90		
D5611	Repair resin partial denture base, mandibular	$90	$90		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5612	Repair resin partial denture base, maxillary	$90	$90		
D5621	Repair cast partial framework, mandibular	$90	$90		
D5622	Repair cast partial framework, maxillary	$90	$90		
D5630	Repair or replace broken retentive clasping materials - per tooth	$120	$120		
D5640	Replace broken teeth - per tooth	$90	$90		
D5650	Add tooth to existing partial denture	$90	$90		
D5660	Add clasp to existing partial denture - per tooth	$120	$120		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit	$290		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit	$290		
D5710	Rebase complete maxillary denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a Benefit	$260		*1 per 12 months*
D5720	Rebase maxillary partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5721	Rebase mandibular partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5725	Rebase hybrid prosthesis	$260	$260	*1 per 36 months*	*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$225	$225	*1 per 36 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5760	Reline maxillary partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	$224	$224	*1 per 36 months*	*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit	$300		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit	$300		*1 per 12 months*
D5850	Tissue conditioning, maxillary	$80	$80		*1 per 12 months*
D5851	Tissue conditioning, mandibular	$80	$80		*1 per 12 months*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES					
- Includes adjustments, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the implant was originally delivered.					
- Replacement of a retainer, pontic, or stress breaker requires the existing bridge to be 60+ months old.					
- FPD, as referenced below, stands for fixed partial denture.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6040	Surgical placement: eposteal implant	$350	Not a Benefit	*1 per 60 months*	
D6050	Surgical placement: transosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6055	Connecting bar – implant supported or abutment supported	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6056	Prefabricated abutment – includes modification and placement	$350	Not a Benefit	*1 per 60 months*	
D6058	Abutment supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6062	Abutment supported cast metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6064	Abutment supported cast metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6065	Implant supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6067	Implant supported crown - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6075	Implant supported retainer for ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$80	Not a Benefit		
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	$270	Not a Benefit		
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6083	Implant supported crown - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6085	Interim implant crown	No cost	Not a Benefit	*1 per 60 months*	
D6086	Implant supported crown - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6087	Implant supported crown - noble alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6088	Implant supported crown - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6089	Accessing and retorquing loose implant screw - per screw	$170	Not a Benefit	*1 per 24 months*	
D6090	Repair implant supported prosthesis, by report	$350	Not a Benefit	*1 per 60 months*	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$270	Not a Benefit		
D6095	Repair implant abutment, by report	$350	Not a Benefit		
D6096	Remove broken implant retaining screw	$170	Not a Benefit	*1 per tooth per 60 months*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6100	Surgical removal of implant body	$250	Not a Benefit		
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$270	Not a Benefit		
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$350	Not a Benefit		
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$255	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6104	Bone graft at time of implant placement	$255	Not a Benefit		
D6105	Removal of implant body not requiring bone removal or flap elevation	$85	Not a Benefit		
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6190	Radiographic/surgical implant index, by report	$200	Not a Benefit	*1 per 60 months*	
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$75	Not a Benefit	*1 per 24 months*	
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.					

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6205	Pontic - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6210	Pontic - cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6212	Pontic - cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250	Not a Benefit	*1 per 60 months*	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6549	Retainer – for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a Benefit	$385		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a Benefit	$380		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a Benefit	$380		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a Benefit	$395		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a Benefit	$415		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a Benefit	$390		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a Benefit	$360		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6750	Retainer crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6792	Retainer crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a Benefit	$350		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$80	$80		
D6940	Stress breaker	Not a Benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	$170	$170		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D7111	Extraction, coronal remnants - primary tooth	Not a Benefit	$60		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$85	$85		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$140	$140		
D7220	Removal of impacted tooth - soft tissue	$150	$150		
D7230	Removal of impacted tooth - partially bony	$225	$225		
D7240	Removal of impacted tooth - completely bony	$245	$245		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220	$220		
D7250	Removal of residual tooth roots (cutting procedure)	$140	$140		
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$245	$140		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$140	$140		
D7280	Exposure of an unerupted tooth	$155	$155		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a Benefit	$110		
D7284	Excisional biopsy of minor salivary glands	Not a Benefit	$100		
D7286	Incisional biopsy of oral tissue -soft	Not a Benefit	$100		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a Benefit	$140		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a Benefit	$160		
D7471	Removal of lateral exostosis (maxilla or mandible)	$250	$250		
D7472	Removal of torus palatinus	Not a Benefit	$250		
D7473	Removal of torus mandibularis	Not a Benefit	$250		
D7509	Marsupialization of odontogenic cyst	Not a Benefit	$160		
D7510	Incision and drainage of abscess - intraoral soft tissue	$100	$100		
D7910	Suture of recent small wounds up to 5 cm	$80	Not a Benefit		
D7921	Collection and application of autologous blood concentrate product	$300	Not a Benefit		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No cost	No cost		
D7961	Buccal/labial frenectomy (frenulectomy)	Not a Benefit	$260		
D7962	Lingual frenectomy (frenulectomy)	Not a Benefit	$260		
D7970	Excision of hyperplastic tissue - per arch	Not a Benefit	$115		
D7971	Excision of pericoronal gingiva	$130	$130		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees (under age 19) ONLY					
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.					
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.					
- Comprehensive orthodontic treatment procedures (D8070, D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted except for services provided by an orthodontist other than the original treating Contract Dentist or dental office.					
- Refer to Schedule B for Limitations and Exclusions for medically necessary orthodontics for additional information.					
D8010	Limited orthodontic treatment of the primary dentition	$350	N/A		
D8020	Limited orthodontic treatment of the transitional dentition	$350	N/A		
D8030	Limited orthodontic treatment of the adolescent dentition	$350	N/A		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	N/A		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	N/A		
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	N/A		
D8210	Removable appliance therapy	$350	N/A		
D8220	Fixed appliance therapy	$350	N/A		
D8660	Pre-orthodontic treatment examination to monitor growth and development	$51	N/A	*1 per 6 months when performed by the same Contract Dentist or dental office*	
D8670	Periodic orthodontic treatment visit	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding*	
D8681	Removable orthodontic retainer adjustment	No cost	N/A		
D8698	Re-cement or re-bond fixed retainer - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8699	Re-cement or re-bond fixed retainer - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8701	Repair of fixed retainer, includes reattachment - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8702	Repair of fixed retainer, includes reattachment - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8000-D8999 XI. ORTHODONTICS – for Adult Enrollees (age 19 and up)					
- Including covered dependent adult children. The Enrollee must continue to be eligible during active treatment.					
- The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.					
- The Retention Copayment includes adjustments and/or office visits up to 24 months.					
Pre and post orthodontic records include:					
The Benefit for pre-treatment records and diagnostic services includes:		N/A	$250		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0322	Tomographic survey	N/A	Included		
D0330	Panoramic radiographic image	N/A	Included		
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	N/A	Included		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	N/A	Included		
D0396	3D printing of a 3D dental surface scan	N/A	No cost		
D0470	Diagnostic casts	N/A	Included		
D0701	Panoramic radiographic image - image capture only	N/A	Included		
D0702	2D cephalometric radiographic image - image capture only	N/A	Included		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	N/A	Included		
D0801	3D dental surface scan - direct	N/A	No cost		
D0802	3D dental surface scan - indirect	N/A	No cost		
D0803	3D facial surface scan - direct	N/A	No cost		
D0804	3D facial surface scan - indirect	N/A	No cost		
The Benefit for post-treatment records includes:		N/A	$70		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0470	Diagnostic casts	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	N/A	Included		
D8040	Limited orthodontic treatment of the adult dentition	N/A	$1,950		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	N/A	$3,250		
D8090	Comprehensive orthodontic treatment of the adult dentition	N/A	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	N/A	$51		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	N/A	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	N/A	$450		*Placement of removable retainers*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8681	Removable orthodontic retainer adjustment	N/A	No cost		
D8698	Re-cement or re-bond fixed retainer - maxillary	N/A	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	N/A	No cost		*2 per 6 months*
D8701	Repair of fixed retainer, includes reattachment - maxillary	N/A	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	N/A	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	N/A	$250		*Includes treatment planning session*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain - per visit	$45	$45		
D9211	Regional block anesthesia	Not a Benefit	No cost		
D9212	Trigeminal division block anesthesia	Not a Benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a Benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a Benefit	No cost		
D9222	Deep sedation/general anesthesia - first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$45	$45		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Not a Benefit	$10		
D9440	Office visit - after regularly scheduled hours	Not a Benefit	$45		
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a Benefit	$10		
D9610	Therapeutic parenteral drug, single administration	$40	Not a Benefit		
D9912	Pre-visit patient screening	No cost	No cost		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$45	Not a Benefit		
D9932	Cleaning and inspection of removable complete denture, maxillary	No cost	No cost		
D9933	Cleaning and inspection of removable complete denture, mandibular	No cost	No cost		
D9934	Cleaning and inspection of removable partial denture, maxillary	No cost	No cost		
D9935	Cleaning and inspection of removable partial denture, mandibular	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9943	Occlusal guard adjustment	$40	$40	*1 per 12 months (6 months after initial placement)*	*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard – hard appliance, full arch	$295	$295	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard – soft appliance, full arch	$75	$75	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard – hard appliance, partial arch	$150	$150	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a Benefit	$65		
D9952	Occlusal adjustment - complete	Not a Benefit	$265		*1 per 36 months*
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a Benefit	$125		*Limited to 1 bleaching tray and gel for 2 weeks of self- treatment*
D9986	Missed appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9987	Cancelled appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9990	Certified translation or sign language services - per visit	No cost	No cost		
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	No cost	No cost		

Endnotes:

Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for an implant/abutment supported crown or fixed bridge retainer, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

Name brand, laboratory processed, or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

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

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

SCHEDULE B

Limitations and Exclusions of Benefits
Delta Dental Individual & Family™
DeltaCare® USA
Preferred Plan for Families / Basic Plan for Families

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

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).

4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high-quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captee, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Contact the Customer Service Center at 888-857-0337 if You have questions regarding the additional fee or name brand services.

5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on Schedule A, Description of Benefits and Copayments. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

6. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).

7. Your cost for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

Exception to extend covered orthodontics Benefits to a cancelled or terminated Contract is as follows:

a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures or is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures as shown on *Schedule A*.

6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

8. Consultations or other diagnostic services for non-covered Benefits.

9. Dental services received from any dental facility other than the Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

11. Prescription and over-the-counter drugs.

12. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage

13. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Changes in orthodontic treatment necessitated by accident of any kind.

15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures as shown on Schedule A.

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

17. Orthodontics, including oral evaluations and all treatment must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

18. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

19. Services or supplies for sleep apnea.

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

Limitations of Benefits for Pediatric Enrollees

The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

1. Isolated bitewing or periapical images are allowed on an emergency or episodic basis.

2. Additional coverage of Panoramic and cephalometric images (D0330, D0340, D0701, D0702) is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

3. Sealants (D1351, D1352) are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

4. Space maintainers are a Benefit when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

5. Restorations, crowns, inlays and onlays are Benefits only if necessary to treat diseased or fractured teeth.

6. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm, frenectomy and crown lengthening.

7. Wisdom teeth (third molars) extracted for Enrollees under age 15 are not eligible for payment in the absence of specific pathology.

8. In the case of an Emergency Service involving pain or a condition requiring immediate treatment, the plan covers necessary diagnostic and therapeutic dental procedures administered by and Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

9. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and

    b. Either of the following:
        i. The existing non-functional restoration/bridge/denture was placed 60 or more months prior to its replacement, or
        ii. If an existing partial denture is less than 60 months old but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

10. Deep sedation/general anesthesia and/or intravenous moderate sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more soft tissue, partial or full bony impactions (Procedures D7220, D7230, D7240, and D7241).

11. Deep sedation/general anesthesia or intravenous moderate sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

12. Benefits provided by a pediatric Dentist are limited to children through age thirteen following an attempt by the Contract Dentist to treat the child and upon prior Authorization by Us, less applicable Copayments. The Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.

Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Except as specifically provided, the following services, supplies, or charges are not covered:

1. Any dental service or treatment not specifically listed under *Schedule A*, *Description of Benefits and Copayments*, as a covered service.

2. Dental services received from any dental facility other than the Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

3. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the Enrollee by a Contract Dentist unless the dentist notifies the Enrollee of his/her liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records.)

4. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

    a. has a poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

    b. is inconsistent with meeting accepted standards of dental practice.

5. Those services or supplies which are experimental or investigative (deemed unproven).

6. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.

7. Those resulting from the Enrollee's failure to comply with professionally prescribed treatment or due to lack of cooperation with the Contract Dentist or dental office.

8. Those started or performed prior to the Enrollee's effective coverage date.

9. Those incurred after the termination date of the Enrollee's eligibility for coverage unless otherwise indicated.

10. Consultations or other diagnostic services for non-covered Benefits.

11. Services and/or appliances to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

12. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges), orthodontic or other appliances.

14. Duplicate and temporary devices, appliances, and services.

15. For implants, surgical insertion; and/or removal of, and any appliances and/or crowns attached to implants.

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

17. Deep sedation/general anesthesia for covered procedures on the same date of service as intravenous conscious sedation/analgesia.

18. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided prior Authorization is obtained.

19. Services or treatment provided by a member of the Enrollee's immediate family.

20. Those services submitted by a dentist which are for the same services performed on the same date for the same Enrollee by another dentist.

21. Those performed by a dentist who is compensated by a facility for similar covered services performed for Enrollees.

22. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of their license and applicable state law.

23. Those which are for any illness or bodily injury which occurs in the course of employment if Benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the member claims the Benefits or compensation.

24. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.

25. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.

26. Those for which the Enrollee would have no obligation to pay in the absence of this or any similar coverage.

27. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

28. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

29. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.

30. Services or treatment provided as a result of intentionally self-inflicted injury or illness.

31. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.

32. For assistant at surgery.

33. Any charges for failure to keep a scheduled appointment.

34. Any services that are considered strictly cosmetic in nature including, but not limited to, bleaching, veneer facing, bridges and/or denture, and charges for personalization or characterization of prosthetic appliances.

35. Services related to the diagnosis and treatment of jaw joint problems, including, but not limited, to Temporomandibular Joint Dysfunction (TMJD), craniomandibular disorders, or other conditions of the joint linking the jawbone or the complex of muscles, nerves and other tissues related to that joint.

36. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

37. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

38. Prescription and over-the-counter drugs, home care items, vitamins or dietary supplements.

39. Adjunctive dental services as defined by applicable federal regulations. These are medical services that may be covered under a medical policy even when provided by a general dentist or oral surgeon.

40. Charges for copies of Enrollees' records, charts or images, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or images.

41. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

42. State or territorial taxes on dental services performed.

43. Services or supplies for sleep apnea.

Policies, Limitations, and Exclusions for Medically Necessary Orthodontic Services for Pediatric Enrollees:

1. Services are limited to medically necessary orthodontics when provided by a Contract Dentist. Orthodontic treatment is a Benefit of this plan only when medically necessary as evidenced by a severe handicapping malocclusion for Pediatric Enrollees and shall be prior authorized by the plan.

2. 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.

3. The automatic qualifying conditions are:

   a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,

   b. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

   c. A crossbite of individual anterior teeth causing destruction of soft tissue,

   d. Severe traumatic deviation.

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

5. The allowances for comprehensive orthodontic treatment procedures (D8070, D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.

6. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

7. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Pediatric Enrollees and shall be prior authorized.

8. 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.

9. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

10. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the plan 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 Contract Dentist's charge for the specialized orthodontic appliance or procedure.

11. Repair and replacement of an orthodontic appliance inserted under the plan that has been damaged, lost, stolen, or misplaced is not a covered service.

12. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

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

    a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

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

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

13. Orthodontics, including oral evaluations and all treatment, must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

14. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

DeltaCare® USA

Delta Dental of Pennsylvania
300 Corporate Center Drive
Camp Hill, PA 17011-1744
deltadentalins.com

Delta Dental Individual & Family™

DeltaCare® USA
Basic Plan for Families

Outline of Coverage

Read Your Policy carefully. This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance Policy and only the Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore important that You READ YOUR POLICY CAREFULLY. The Policy provides Benefits for dental care only.

If You are not satisfied with the Policy for any reason, You may return the Policy within 10 days after You receive it. Mail or deliver it to Delta Dental of Pennsylvania ("Delta Dental"). Any Premium paid will be refunded. The Policy will then be void from its start.

IMPORTANT: In the event of any inconsistency between this outline of coverage and the Policy, the terms of the Policy will control.

Renewal	
Renewability:	**Renewal** This Policy remains in effect for the Policy Year, provided it is not terminated by Us or by the Primary Enrollee. The Primary Enrollee will receive renewal information from the Exchange prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the Exchange during the Open Enrollment Period. Provided We continue to make this Policy available through the Exchange at the renewal period: ▪ the Primary Enrollee may elect to choose this Policy, subject to the applicable Premium through the Exchange for this plan at the time of renewal; or ▪ the Primary Enrollee may not have to make an election through the Exchange in subsequent Open Enrollment Periods to continue coverage. You should refer to the Exchange rules regarding automatic renewal of coverage.

Description of Benefits and Copayments
Delta Dental Individual & Family™
DeltaCare® USA
Basic Plan for Families

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Pediatric Enrollee	**$425.00** each Calendar Year
Multiple Pediatric Enrollees	**$850.00** each Calendar Year

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

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

We recommend that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If You have any questions regarding Your OOPM, please contact the Customer Service Center at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	$15	$15	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	No cost	No cost		
D0140	Limited oral evaluation - problem focused	No cost	No cost		
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No cost	Not a Benefit		
D0150	Comprehensive oral evaluation - new or established patient	No cost	No cost		
D0160	Detailed and extensive oral evaluation - problem focused, by report	No cost	No cost		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	Not a Benefit	No cost		
D0171	Re-evaluation – post-operative office visit	Not a Benefit	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	No cost	No cost		
D0190	Screening of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral - comprehensive series of radiographic images	$10	$10	*1 of (D0210 or D0330) series per 36 months*	*1 of (D0210 or D0330) series per 24 months*
D0220	Intraoral - periapical first radiographic image	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0230	Intraoral - periapical each additional radiographic image	No cost	No cost		
D0240	Intraoral - occlusal radiographic image	No cost	No cost		
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	Not a Benefit	No cost		
D0270	Bitewing - single radiographic image	No cost	No cost		
D0272	Bitewings - two radiographic images	No cost	No cost		
D0273	Bitewings - three radiographic images	No cost	No cost		
D0274	Bitewings - four radiographic images	No cost	No cost	*1 series per 6 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No cost	$10		
D0330	Panoramic radiographic image	$10	$25	*1 of (D0330 or D0210) per 36 months*	*1 of (D0330 or D0210) series per 24 months*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$10	Not a Benefit		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$10	Not a Benefit		
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No cost	Not a Benefit		
D0415	Collection of microorganisms for culture and sensitivity	Not a Benefit	No cost		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a Benefit	No cost		
D0460	Pulp vitality tests	Not a Benefit	No cost		
D0470	Diagnostic casts	$30	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image - image capture only	No cost	No cost		
D0702	2D cephalometric radiographic image - image capture only	No cost	Not a Benefit		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No cost	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0706	Intraoral - occlusal radiographic image - image capture only	No cost	No cost		
D0707	Intraoral - periapical radiographic image - image capture only	No cost	No cost		
D0708	Intraoral - bitewing radiographic image - image capture only	No cost	No cost		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a Benefit	$45		*Up to 2 additional cleanings per 12 months*
D1120	Prophylaxis - child	$15	Not a Benefit	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	
D1206	Topical application of fluoride varnish	$10	$5	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride – excluding varnish	$10	$5	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	Not a Benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a Benefit	No cost		
D1330	Oral hygiene instructions	Not a Benefit	No cost		
D1351	Sealant - per tooth	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	
D1352	Preventive resin restoration in a moderate to high caries	$15	Not a Benefit	*Permanent molars without*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	risk patient – permanent tooth			*restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	
D1354	Application of caries arresting medicament – per tooth	$10	$5	*1 per 6 months*	*2 per 12 months*
D1510	Space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit		
D1516	Space maintainer – fixed – bilateral, maxillary	$195	Not a Benefit		
D1517	Space maintainer – fixed – bilateral, mandibular	$195	Not a Benefit		
D1520	Space maintainer - removable, unilateral – per quadrant	$140	Not a Benefit		
D1526	Space maintainer – removable – bilateral, maxillary	$195	Not a Benefit		
D1527	Space maintainer – removable – bilateral, mandibular	$195	Not a Benefit		
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$30	Not a Benefit		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$30	Not a Benefit		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$30	Not a Benefit		
D1556	Removal of fixed unilateral space maintainer - per quadrant	$15	Not a Benefit		
D1557	Removal of fixed bilateral space maintainer - maxillary	$15	Not a Benefit		
D1558	Removal of fixed bilateral space maintainer - mandibular	$15	Not a Benefit		
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit	*1 per quadrant per lifetime; Age 8 and under*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.					
D2140	Amalgam - one surface, primary or permanent	$45	$40		
D2150	Amalgam - two surfaces, primary or permanent	$60	$50		
D2160	Amalgam - three surfaces, primary or permanent	$70	$65		
D2161	Amalgam - four or more surfaces, primary or permanent	$85	$80		
D2330	Resin-based composite - one surface, anterior	$75	$70		
D2331	Resin-based composite - two surfaces, anterior	$90	$85		
D2332	Resin-based composite - three surfaces, anterior	$100	$95		
D2335	Resin-based composite - four or more surfaces	$125	$120		
D2390	Resin-based composite crown, anterior	Not a Benefit	$190		
D2391	Resin-based composite - one surface, posterior	Not a Benefit	$75		
D2392	Resin-based composite - two surfaces, posterior	Not a Benefit	$90		
D2393	Resin-based composite - three surfaces, posterior	Not a Benefit	$105		
D2394	Resin-based composite - four or more surfaces, posterior	Not a Benefit	$125		
D2510	Inlay - metallic - one surface	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	$340	$340	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2542	Onlay - metallic - two surfaces	$335	$335	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2610	Inlay - porcelain/ceramic - one surface	Not a Benefit	$350		*1 per 60 months*
D2620	Inlay - porcelain/ceramic - two surfaces	Not a Benefit	$385		*1 per 60 months*
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a Benefit	$405		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not a Benefit	$415		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not a Benefit	$415		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a Benefit	$425		*1 per 60 months*
D2650	Inlay - resin-based composite - one surface	Not a Benefit	$250		*1 per 60 months*
D2651	Inlay - resin-based composite - two surfaces	Not a Benefit	$275		*1 per 60 months*
D2652	Inlay - resin-based composite - three or more surfaces	Not a Benefit	$310		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not a Benefit	$305		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not a Benefit	$330		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not a Benefit	$375		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	Not a Benefit	$125		*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	Not a Benefit	$125		*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a Benefit	$425		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	Not a Benefit	$325		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2722	Crown - resin with noble metal	Not a Benefit	$425		*1 per 60 months*
D2740	Crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2790	Crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2792	Crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2794	Crown - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same dentist/office*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a Benefit	$45		
D2920	Re-cement or re-bond crown	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same dentist/office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a Benefit	$120		*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$200	$200	*1 per 60 months; through age 14*	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$200	Not a Benefit	*1 per 60 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$130	Not a Benefit	*1 per 60 months; through age 14*	
D2931	Prefabricated stainless steel crown - permanent tooth	$200	$200	*1 per 60 months; through age 14*	
D2940	Protective restoration	$40	$25		
D2949	Restorative foundation for an indirect restoration	$125	$125		
D2950	Core buildup, including any pins when required	$125	$125	*1 per 60 months*	
D2951	Pin retention - per tooth, in addition to restoration	$30	$30		
D2952	Post and core in addition to crown, indirectly fabricated	Not a Benefit	$185		*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	Not a Benefit	$70		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	$120	$120	*1 per 60 months; includes canal preparation*	*Includes canal preparation*
D2955	Post removal	Not a Benefit	$40		
D2957	Each additional prefabricated post - same tooth	Not a Benefit	$45		*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	Not a Benefit	$400		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	Not a Benefit	$440		*Limited to replacement of significant tooth structure loss due to caries or fracture*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2962	Labial veneer (porcelain laminate) - indirect	Not a Benefit	$500		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a Benefit	$100		
D2976	Band stabilization – per tooth	$70	$65	*1 per tooth per lifetime*	*once per tooth per lifetime*
D2980	Crown repair necessitated by restorative material failure	$110	$110		
D2981	Inlay repair necessitated by restorative material failure	$110	$110		
D2982	Onlay repair necessitated by restorative material failure	$110	$110		
D2983	Veneer repair necessitated by restorative material failure	$110	$110		
D2989	Excavation of a tooth resulting in the determination of non-restorability	No cost	No cost		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	Not a Benefit	$40		
D3120	Pulp cap - indirect (excluding final restoration)	Not a Benefit	$40		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$80	Not a Benefit		
D3221	Pulpal debridement, primary and permanent teeth	Not a Benefit	$70		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; through age 5*	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; primary molars through age 11*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$270	$270	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$320	$320	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$390	$390	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$270	$270		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$150	$150		
D3333	Internal root repair of perforation defects	Not a Benefit	$115		
D3346	Retreatment of previous root canal therapy - anterior	$350	$350		
D3347	Retreatment of previous root canal therapy - premolar	$350	$350		
D3348	Retreatment of previous root canal therapy - molar	$350	$350		
D3351	Apexification/recalcification – initial visit (apical closure /calcific repair of perforations, root resorption, etc.)	$200	Not a Benefit		
D3352	Apexification/recalcification - interim medication replacement	$200	Not a Benefit		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$300	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3355	Pulpal regeneration - initial visit	$175	Not a Benefit		
D3356	Pulpal regeneration - interim medication replacement	$88	Not a Benefit		
D3357	Pulpal regeneration - completion of treatment	$88	Not a Benefit		
D3410	Apicoectomy - anterior	$280	$280		
D3421	Apicoectomy - premolar (first root)	$290	$290		
D3425	Apicoectomy - molar (first root)	$350	$350		
D3426	Apicoectomy (each additional root)	$150	$150		
D3430	Retrograde filling - per root	Not a Benefit	$120		
D3450	Root amputation - per root	$220	$220		
D3471	Surgical repair of root resorption - anterior	$280	$280		
D3472	Surgical repair of root resorption - premolar	$280	$280		
D3473	Surgical repair of root resorption - molar	$280	$280		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$280	$280		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$280	$280		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$280	$280		
D3911	Intraorifice barrier	No cost	No cost	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3920	Hemisection (including any root removal), not including root canal therapy	$220	$220		
D3921	Decoronation or submergence of an erupted tooth	$85	$85		
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260	$260	*1 per 24 months per quadrant*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$150	$150	*1 per 24 months per quadrant*	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No cost	No cost	*1 per 24 months per quadrant*	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$200	$200	*1 per 24 months per quadrant*	
D4245	Apically positioned flap	Not a Benefit	$135		
D4249	Clinical crown lengthening - hard tissue	$280	$280	*1 per tooth per lifetime*	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$255	$280	*1 per 24 months per quadrant*	
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not a Benefit	$150		
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not a Benefit	$210		
D4267	Guided tissue regeneration, natural teeth - nonresorbable barrier, per site	Not a Benefit	$240		
D4270	Pedicle soft tissue graft procedure	$350	$350		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350	$350		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a Benefit	$105		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a Benefit	$350		
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$350	$350	*1 per 24 months per quadrant*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$350	$350	*1 per 24 months per quadrant*	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$210	$210		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a Benefit	$210		
D4286	Removal of non-resorbable barrier	Not a Benefit	No Cost		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$110	$110	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$65	$65	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$90	$90	*1 per lifetime*	*1 treatment per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$100	$100	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	No cost	No cost	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	$60	$60	*4 treatments per 12 months*	*2 per 12 months*
D4910	Periodontal maintenance	Not a Benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a Benefit	$25		
D4921	Gingival irrigation with a medicinal agent – per quadrant	No cost	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments, rebasing and relining, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments, rebasing and relining, if needed, for the first three months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.					
D5110	Complete denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5140	Immediate denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$40	$40		
D5411	Adjust complete denture - mandibular	$40	$40		
D5421	Adjust partial denture - maxillary	$40	$40		
D5422	Adjust partial denture - mandibular	$40	$40		
D5511	Repair broken complete denture base, mandibular	$90	$90		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5512	Repair broken complete denture base, maxillary	$90	$90		
D5520	Replace missing or broken teeth - complete denture (each tooth)	$90	$90		
D5611	Repair resin partial denture base, mandibular	$90	$90		
D5612	Repair resin partial denture base, maxillary	$90	$90		
D5621	Repair cast partial framework, mandibular	$90	$90		
D5622	Repair cast partial framework, maxillary	$90	$90		
D5630	Repair or replace broken retentive/clasping materials - per tooth	$120	$120		
D5640	Replace broken teeth - per tooth	$90	$90		
D5650	Add tooth to existing partial denture	$90	$90		
D5660	Add clasp to existing partial denture - per tooth	$120	$120		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit	$290		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit	$290		
D5710	Rebase complete maxillary denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a Benefit	$260		*1 per 12 months*
D5720	Rebase maxillary partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5721	Rebase mandibular partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5725	Rebase hybrid prosthesis	$260	$260	*1 per 36 months*	*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5730	Reline complete maxillary denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$225	$225	*1 per 36 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	$224	$224	*1 per 36 months*	*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit	$300		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit	$300		*1 per 12 months*
D5850	Tissue conditioning, maxillary	$80	$80		*1 per 12 months*
D5851	Tissue conditioning, mandibular	$80	$80		*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES					
- Includes adjustments, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the implant was originally delivered.					
- Replacement of a retainer, pontic, or stress breaker requires the existing bridge to be 60+ months old.					
- FPD, as referenced below, stands for fixed partial denture.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6040	Surgical placement: eposteal implant	$350	Not a Benefit	*1 per 60 months*	
D6050	Surgical placement: transosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6055	Connecting bar – implant supported or abutment supported	$350	Not a Benefit	*1 per 60 months*	
D6056	Prefabricated abutment – includes modification and placement	$350	Not a Benefit	*1 per 60 months*	
D6058	Abutment supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6062	Abutment supported cast metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6064	Abutment supported cast metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6065	Implant supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6067	Implant supported crown - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6075	Implant supported retainer for ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$80	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
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	$270	Not a Benefit		
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6083	Implant supported crown - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6085	Interim implant crown	No cost	Not a Benefit	*1 per 60 months*	
D6086	Implant supported crown - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6087	Implant supported crown - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6088	Implant supported crown - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6089	Accessing and retorquing loose implant screw – per screw	$170	Not a Benefit	*1 per 24 months*	
D6090	Repair implant supported prosthesis, by report	$350	Not a Benefit	*1 per 60 months*	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$270	Not a Benefit		
D6095	Repair implant abutment, by report	$350	Not a Benefit		
D6096	Remove broken implant retaining screw	$170	Not a Benefit	*1 per tooth per 60 months*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6100	Surgical removal of implant body	$250	Not a Benefit		
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$270	Not a Benefit		
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$350	Not a Benefit		
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$255	Not a Benefit		
D6104	Bone graft at time of implant placement	$255	Not a Benefit		
D6105	Removal of implant body not requiring bond removal or flap elevation	$85	Not a Benefit		
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6190	Radiographic/surgical implant index, by report	$200	Not a Benefit		
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$75	Not a Benefit	*1 per 24 months*	
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.					
D6205	Pontic - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6210	Pontic - cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6212	Pontic - cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6251	Pontic - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250	Not a Benefit	*1 per 60 months*	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6549	Retainer – for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a Benefit	$385		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a Benefit	$380		*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a Benefit	$380		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a Benefit	$395		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a Benefit	$415		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a Benefit	$390		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a Benefit	$360		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6790	Retainer crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6792	Retainer crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a Benefit	$350		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$80	$80		
D6940	Stress breaker	Not a Benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	$170	$170		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D7111	Extraction, coronal remnants - primary tooth	Not a Benefit	$60		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$85	$85		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$140	$140		
D7220	Removal of impacted tooth - soft tissue	$150	$150		
D7230	Removal of impacted tooth - partially bony	$225	$225		
D7240	Removal of impacted tooth - completely bony	$245	$245		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220	$220		
D7250	Removal of residual tooth roots (cutting procedure)	$140	$140		
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	$245	$140		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$140	$140		
D7280	Exposure of an unerupted tooth	$155	$155		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a Benefit	$110		
D7284	Excisional biopsy of minor salivary glands	Not a Benefit	$100		
D7286	Incisional biopsy of oral tissue -soft	Not a Benefit	$100		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a Benefit	$140		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a Benefit	$160		
D7471	Removal of lateral exostosis (maxilla or mandible)	$250	$250		
D7472	Removal of torus palatinus	Not a Benefit	$250		
D7473	Removal of torus mandibularis	Not a Benefit	$250		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7509	Marsupialization of odontogenic cyst	Not a Benefit	$160		
D7510	Incision and drainage of abscess - intraoral soft tissue	$100	$100		
D7910	Suture of recent small wounds up to 5 cm	$80	Not a Benefit		
D7921	Collection and application of autologous blood concentrate product	$300	Not a Benefit		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No cost	No cost		
D7961	Buccal/labial frenectomy (frenulectomy)	Not a Benefit	$260		
D7962	Lingual frenectomy (frenulectomy)	Not a Benefit	$260		
D7970	Excision of hyperplastic tissue - per arch	Not a Benefit	$115		
D7971	Excision of pericoronal gingiva	$130	$130		
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees (under age 19) ONLY					
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.					
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.					
- Comprehensive orthodontic treatment procedures (D8070, D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted except for services provided by an orthodontist other than the original treating Contract Dentist or dental office.					
- Refer to Schedule B for Limitations and Exclusions for medically necessary orthodontics for additional information.					
D8010	Limited orthodontic treatment of the primary dentition	$350	N/A		
D8020	Limited orthodontic treatment of the transitional dentition	$350	N/A		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8030	Limited orthodontic treatment of the adolescent dentition	$350	N/A		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	N/A		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	N/A		
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	N/A		
D8210	Removable appliance therapy	$350	N/A		
D8220	Fixed appliance therapy	$350	N/A		
D8660	Pre-orthodontic treatment examination to monitor growth and development	$51	N/A	*1 per 6 months when performed by the same Contract Dentist or dental office*	
D8670	Periodic orthodontic treatment visit	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding*	
D8681	Removable orthodontic retainer adjustment	No cost	N/A		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8698	Re-cement or re-bond fixed retainer - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8699	Re-cement or re-bond fixed retainer - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8701	Repair of fixed retainer, includes reattachment - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8702	Repair of fixed retainer, includes reattachment - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8000-D8999 XI. ORTHODONTICS – for Adult Enrollees (age 19 and up)					
- Including covered dependent adult children. The Enrollee must continue to be eligible during active treatment.					
- The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.					
- The Retention Copayment includes adjustments and/or office visits up to 24 months.					
Pre and post orthodontic records include:					
The Benefit for pre-treatment records and diagnostic services includes:		N/A	$250		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0322	Tomographic survey	N/A	Included		
D0330	Panoramic radiographic image	N/A	Included		
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	N/A	Included		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	N/A	Included		
D0396	3D printing of a 3D dental surface scan	N/A	No cost		
D0470	Diagnostic casts	N/A	Included		
D0701	Panoramic radiographic image - image capture only	N/A	Included		
D0702	2D cephalometric radiographic image - image capture only	N/A	Included		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	N/A	Included		
D0801	3D dental surface scan – direct	N/A	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0802	3D dental surface scan – indirect	N/A	No cost		
D0803	3D facial surface scan – direct	N/A	No cost		
D0804	3D facial surface scan – indirect	N/A	No cost		
The Benefit for post-treatment records includes:		N/A	$70		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0470	Diagnostic casts	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	N/A	Included		
D8040	Limited orthodontic treatment of the adult dentition	N/A	$1,950		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	N/A	$3,250		
D8090	Comprehensive orthodontic treatment of the adult dentition	N/A	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	N/A	$51		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	N/A	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	N/A	$450		*Placement of removable retainers*
D8681	Removable orthodontic retainer adjustment	N/A	No cost		
D8698	Re-cement or re-bond fixed retainer - maxillary	N/A	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	N/A	No cost		*2 per 6 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8701	Repair of fixed retainer, includes reattachment - maxillary	N/A	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	N/A	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	N/A	$250		*Includes treatment planning session*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain - per visit	$45	$45		
D9211	Regional block anesthesia	Not a Benefit	No cost		
D9212	Trigeminal division block anesthesia	Not a Benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a Benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a Benefit	No cost		
D9222	Deep sedation/general anesthesia - first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$45	$45		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Not a Benefit	$10		
D9440	Office visit - after regularly scheduled hours	Not a Benefit	$45		
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a Benefit	$10		
D9610	Therapeutic parenteral drug, single administration	$40	Not a Benefit		
D9912	Pre-visit patient screening	No cost	No cost		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$45	Not a Benefit		
D9932	Cleaning and inspection of removable complete denture, maxillary	No cost	No cost		
D9933	Cleaning and inspection of removable complete denture, mandibular	No cost	No cost		
D9934	Cleaning and inspection of removable partial denture, maxillary	No cost	No cost		
D9935	Cleaning and inspection of removable partial denture, mandibular	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9943	Occlusal guard adjustment	$40	$40	*1 per 12 months (6 months after initial placement)*	*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard – hard appliance, full arch	$295	$295	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard – soft appliance, full arch	$75	$75	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard – hard appliance, partial arch	$150	$150	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a Benefit	$65		
D9952	Occlusal adjustment - complete	Not a Benefit	$265		*1 per 36 months*
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a Benefit	$125		*Limited to one bleaching tray and gel for two weeks of self-treatment*
D9986	Missed appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9987	Cancelled appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9990	Certified translation or sign language services - per visit	No cost	No cost		
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	No cost	No cost		

Endnotes:

Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for an implant/abutment supported crown or fixed bridge retainer, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

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

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

Limitations and Exclusions of Benefits
Delta Dental Individual & Family™
DeltaCare® USA
Preferred Plan for Families / Basic Plan for Families

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

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).

4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Contact the Customer Service Center at 888-857-0337 if You have questions regarding the additional fee or name brand services.

5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on Schedule A, Description of Benefits and Copayments. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

6. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).

7. Your cost for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

   Exception to extend covered orthodontics Benefits to a cancelled or terminated Contract is as follows:

   a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures as shown on *Schedule A*.

6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

8. Consultations or other diagnostic services for non-covered Benefits.

9. Dental services received from any dental facility other than the Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

11. Prescription and over-the-counter drugs.

12. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage

13. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Changes in orthodontic treatment necessitated by accident of any kind.

15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures as shown on *Schedule A*.

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

17. Orthodontics, including oral evaluations and all treatment must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

18. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

19. services or supplies for sleep apnea.

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

Limitations of Benefits for Pediatric Enrollees

The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

1. Isolated bitewing or periapical images are allowed on an emergency or episodic basis.

2. Additional coverage of Panoramic and cephalometric images (D0330, D0340, D0701, D0702) is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

3. Sealants (D1351, D1352) are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

4. Space maintainers are a Benefit when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

5. Restorations, crowns, inlays and onlays are Benefits only if necessary to treat diseased or fractured teeth.

6. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm, frenectomy and crown lengthening.

7. Wisdom teeth (third molars) extracted for Enrollees under age 15 are not eligible for payment in the absence of specific pathology.

8. In the case of an Emergency Service involving pain or a condition requiring immediate treatment, the plan covers necessary diagnostic and therapeutic dental procedures administered by and Out-of-Network Dentist up to the difference between the Out-of- Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

9. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and

    b. Either of the following:
        i. The existing non-functional restoration/bridge/denture was placed 60 or more months prior to its replacement, or
        ii. If an existing partial denture is less than 60 months old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

10. Deep sedation/general anesthesia and/or intravenous moderate sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more soft tissue, partial or full bony impactions (Procedures D7220, D7230, D7240, and D7241).

11. Deep sedation/general anesthesia or intravenous moderate sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

12. Benefits provided by a pediatric Dentist are limited to children through age thirteen following an attempt by the Contract Dentist to treat the child and upon prior Authorization by Us, less applicable Copayments. The Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.

Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Except as specifically provided, the following services, supplies, or charges are not covered:

1. Any dental service or treatment not specifically listed under *Schedule A*, *Description of Benefits and Copayments*, as a covered service.

2. Dental services received from any dental facility other than the Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

3. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the Enrollee by a Contract Dentist unless the dentist notifies the Enrollee of his/her liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records.)

4. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

    a. has a poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

    b. is inconsistent with meeting accepted standards of dental practice.

5. Those services or supplies which are experimental or investigative (deemed unproven).

6. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.

7. Those resulting from the Enrollee's failure to comply with professionally prescribed treatment or due to lack of cooperation with the Contract Dentist or dental office.

8. Those started or performed prior to the Enrollee's effective coverage date.

9. Those incurred after the termination date of the Enrollee's eligibility for coverage unless otherwise indicated.

10. Consultations or other diagnostic services for non-covered Benefits.

11. Services and/or appliances to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

12. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges), orthodontic or other appliances.

14. Duplicate and temporary devices, appliances, and services.

15. For implants, surgical insertion; and/or removal of, and any appliances and/or crowns attached to implants.

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

17. Deep sedation/general anesthesia for covered procedures on the same date of service as intravenous conscious sedation/analgesia.

18. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided prior Authorization is obtained.

19. Services or treatment provided by a member of the Enrollee's immediate family.

20. Those services submitted by a dentist which are for the same services performed on the same date for the same Enrollee by another dentist.

21. Those performed by a dentist who is compensated by a facility for similar covered services performed for Enrollees.

22. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of their license and applicable state law.

23. Those which are for any illness or bodily injury which occurs in the course of employment if Benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the member claims the Benefits or compensation.

24. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.

25. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.

26. Those for which the Enrollee would have no obligation to pay in the absence of this or any similar coverage.

27. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

28. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

29. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.

30. Services or treatment provided as a result of intentionally self-inflicted injury or illness.

31. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.

32. For assistant at surgery.

33. Any charges for failure to keep a scheduled appointment.

34. Any services that are considered strictly cosmetic in nature including, but not limited to, bleaching, veneer facing, bridges and/or denture, and charges for personalization or characterization of prosthetic appliances.

35. Services related to the diagnosis and treatment of jaw joint problems, including, but not limited, to Temporomandibular Joint Dysfunction (TMJD), craniomandibular disorders, or other conditions of the joint linking the jaw bone or the complex of muscles, nerves and other tissues related to that joint.

36. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

37. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

38. Prescription and over-the-counter drugs, home care items, vitamins or dietary supplements.

39. Adjunctive dental services as defined by applicable federal regulations. These are medical services that may be covered under a medical policy even when provided by a general dentist or oral surgeon.

40. Charges for copies of Enrollees' records, charts or images, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or images.

41. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

42. State or territorial taxes on dental services performed.

43. Services or supplies for sleep apnea.

Policies, Limitations, and Exclusions for Medically Necessary Orthodontic Services for Pediatric Enrollees:

1. Services are limited to medically necessary orthodontics when provided by a Contract Dentist. Orthodontic treatment is a Benefit of this plan only when medically necessary as evidenced by a severe handicapping malocclusion for Pediatric Enrollees and shall be prior authorized by the plan.

2. 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.

3. The automatic qualifying conditions are:

    a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,

    b. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

    c. A crossbite of individual anterior teeth causing destruction of soft tissue,

    d. Severe traumatic deviation.

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

5. The allowances for comprehensive orthodontic treatment procedures (D8070, D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.

6. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

7. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Pediatric Enrollees and shall be prior authorized.

8. 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.

9. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

10. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the plan 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 Contract Dentist's charge for the specialized orthodontic appliance or procedure.

11. Repair and replacement of an orthodontic appliance inserted under the plan that has been damaged, lost, stolen, or misplaced is not a covered service.

12. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

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

    a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

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

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

13. Orthodontics, including oral evaluations and all treatment, must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

14. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

We are required by law to maintain the privacy and security of your Protected Health Information (PHI). Protected Health Information (PHI) is information that is maintained or transmitted by Delta Dental, which may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. We receive, use and disclose your PHI to administer your benefit plan as permitted or required by law.

We must follow the federal and state privacy requirements described that apply to our administration of your benefits and provide you with a copy of this notice. We reserve the right to change our privacy practices when needed and we promptly post the updated notice within 60 days on our website.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. Examples of this include processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers, determine your eligibility for services, billing you or your plan sponsor.

If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services on our behalf to administer your benefits. Any third-party affiliates performing services on our behalf has signed a contract agreeing to protect the confidentiality of your PHI and has implemented privacy policies and procedures that comply with applicable federal and state law.

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures made with your authorization

We will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by providing a written request. Your request must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will only maintain PHI that we obtain or utilize in providing your health care benefits. We may not maintain some PHI, such as treatment records or x-rays after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that we do not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI; however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency.

You have the right to correct or update your PHI.
You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal within 60 days. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information.

You have rights related to the use and disclosure of your PHI for marketing.
We will obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the right to withdraw your authorization at any time. We do not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.
You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes

of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another accounting within 12 months.

You have the right to a paper copy of this notice.
A copy of this notice is posted on our website. You may also request that a copy be sent to you.

You have the right to be notified following a breach of unsecured protected health information.
We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

You have the right to choose someone to act for you.
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS
You may file a complaint with us and/or with the U.S. Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact us by calling 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after March 1, 2019.

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 1-866-530-9675 (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 1-866-530-9675 (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 1-866-530-9675 (TTY: 711)。(Chinese)

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 1-866-530-9675 (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 1-866-530-9675 (TTY: 711)번으로 연락하십시오. (Korean)

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 1-866-530-9675 (TTY: 711). (Tagalog)

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 1-866-530-9675 (телетайп: 711). (Russian)

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 1-866-530-9675 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-866-530-9675 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n’est pas le cas, nous pouvons faire en sorte que quelqu’un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l’assistance gratuitement, veuillez appeler le 1-866-530-9675 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-866-530-9675 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-866-530-9675 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-866-530-9675 (TTY: 711). (Italian)

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、 1-866-530-9675 (TTY: 711) までお問い合わせください。 (Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-866-530-9675 (Schreibtelefon: 711). (German)

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: 1-866-530-9675 (TTY: 711). (Persian Farsi)

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 1-866-530-9675 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-866-530-9675 (TTY: 711) (Thai)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-866-530-9675 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-866-530-9675 (TTY՝ 711): (Armenian)

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 1-866-530-9675 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបាន ឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-866-530-9675 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען אײַך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אָנקלינגען אָט די דאָזיקע נומער: 1-866-530-9675 ס׳איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta’go bíníghah? Doo bíníghahgóó éí nich’į’ yídóołtahígíí nihee hóló. Díí naaltsoos t’áá Diné bizaad k’ehjí ályaago ałdó’ nich’į’ ádoolnį́łgo bíighah. T’áá jíík’e shíká i’doolwoł nínízingo kojį’ béésh holdíílnih 1-866-530-9675 (TTY: 711) (Navajo)

Non-Discrimination Disclosure

Discrimination is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330
1-866-530-9675
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT, and WV. DeltaVision is administered by Vision Service Plan (VSP).

deltadentalins.com

ENROLLEE NOTICES

Federal and state laws require enrollees to be notified on a periodic basis about enrollee rights and privacy practices. Below is a summary of the notices that are available under the legal or privacy section of our webpage. To access the most current version and the full text of each notice, please visit our website at deltadentalins.com.

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.

- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.

- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color,

national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

- **Language Assistance Notice and Survey:** We provide phone interpretation to callers who do not speak English. In California, we will also provide, on request, a translated copy of certain vital documents in either Spanish or Chinese. In Maryland and Washington DC, enrollees may receive grievance materials in Spanish or Chinese.

State Notices:

- **CA Financial Privacy Notice:** This notice to Californians describes our demographic and financial information collection and sharing practices. It is similar to the Gramm-Leach-Bliley (GLB) notice described above.

- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.
- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.

- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

- **CA Annual Deductible and OOP Max Accrual Balances:** California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.
- **CA Request Confidential Communications:** This notice informs subscribers of methods of contacting the plan when there is a need or desire to provide and alternative address to received protected health information. Users may also choose to use the "Request for Confidential Communication" form when submitting such request.

For questions concerning the notices, please contact us at 866-530-9675**.** You may also write to us at:

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330