DeltaCare® USA

COVERED CALIFORNIA

DeltaCare USA

Children's Dental HMO for Small Businesses

[Group Name]

[Group No.]

[Effective Date]

[Revised]

Combined Evidence of Coverage and Disclosure Form **("EOC")**

Provided by:

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
888-282-8528
deltadentalins.com

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
888-282-8528
deltadentalins.com

CoveredCA.com
800-300-1506

NOTICE: THIS EOC CONSTITUTES ONLY A SUMMARY OF YOUR GROUP DENTAL PLAN AND ITS ACCURACY SHOULD BE VERIFIED BEFORE RECEIVING TREATMENT. AS REQUIRED BY THE CALIFORNIA HEALTH AND SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. THIS INFORMATION IS NOT A GUARANTEE OF COVERED BENEFITS, SERVICES OR PAYMENTS.

A STATEMENT DESCRIBING DELTA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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INTRODUCTION

We are pleased to welcome you to the DeltaCare USA dental plan ("Plan"). Your employer has chosen to participate in the Exchange and you have selected Delta Dental of California ("Delta Dental") to meet your dental insurance needs. This Plan is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.

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 one on a regular basis.

Eligibility under this Plan is determined by your employer and is defined in the following section:

- ***Eligibility Requirements for Pediatric Benefits*** **("Essential Health Benefits")**

Using This EOC

This EOC, including Attachments, 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 this Plan works and how to obtain dental care.

Please read this EOC completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental or the Administrator. In addition, please read the "Definitions" section as it will explain any words with special or technical meanings. Persons with special health care needs should read the section entitled "Special Health Care Need."

This EOC is *not* a Summary Plan Description to meet the requirements of Employee Retirement Income Security Act of 1974 ("ERISA").

Identification Number

The Enrollee should provide their identification ("ID") number to their Dentist whenever dental services are received. ID cards are not required but may be obtained by visiting our website at deltadentalins.com.

Contract - The Benefit explanations contained in this EOC are subject to all provisions of the Contract on file with your employer ("Contractholder") and do not modify the terms and conditions of the Contract in any way. A copy of the Contract will be furnished to you upon request. Any direct conflict between the Contract and this EOC will be resolved according to the terms which are most favorable to you.

Contact Us - For more information, please visit our website at deltadentalins.com or call our Customer Care at **888-282-8528**. If you prefer to write us with your question(s), please mail your inquiry to the following address:

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

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

DEFINITIONS

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

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described throughout this EOC 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. The Administrator will answer calls directed to **888-282-8528**.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit to Enrollees under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of the Contract and as described in this EOC.

Billed for the Charge: a bill that provides, at a minimum, an accurate itemization of the Premium amounts due, the due dates(s), and the period of time covered by the Premium(s).

Contract: the agreement between Delta Dental and the Contractholder, including any Attachments, pursuant to which Delta Dental has issued this EOC.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Plan.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Plan which covers medically necessary orthodontics.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Plan.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Contractholder: an employer that is deemed eligible by the Exchange and has contracted for Benefits under this Plan through the Exchange.

Copayment: the amount listed in the Schedules attached to this EOC and charged to an Enrollee by a Contract Dentist, Contract Orthodontist or Contract Specialist for the Benefits under this Plan. Copayments must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

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

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Effective Date: the original date the Contract starts.

Eligible Pediatric Individual: a person who is eligible to enroll for Pediatric Benefits as described in this EOC.

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part, or
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Employee: an individual employed by the Contractholder electing coverage for Eligible Pediatric Enrollees as described in this EOC.

Enrollee: an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under this Plan.

Enrollee Effective Date: the date the Exchange reports coverage will begin for each Enrollee.

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

Exchange: the California Health Benefit Exchange also referred to as "Covered California™."

Grace Period: the period of at least [30] consecutive days beginning the day the [Notice of Start of Grace Period] is dated.

[Notice of End of Coverage]: the notice sent by us notifying the recipient that coverage has been cancelled.

[Notice of Start of Grace Period]: the notice sent by us notifying the recipient that coverage will be cancelled unless the Premium amount due is received no later than the last day of the Grace Period.

Open Enrollment Period: the period of the year that the employer has established when Employees may change coverage selections for the next Contract Year.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this EOC.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of the Contract.

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

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

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-child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125 or the Exchange.

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

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to their assigned

Contract Dentist facility because of a physical disability and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

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

Spouse: a person related to or a domestic partner of the Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Employee resides; or
- as may be recognized by the Contractholder.

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Waiting Period (if applicable): the amount of time an Enrollee must be enrolled under the Contract for specific services to be covered.

We, Us and Our: Delta Dental or the Administrator, as appropriate.

You, Your or Yourself: the individuals who are receiving dental services.

ELIGIBILITY AND ENROLLMENT

The Exchange is responsible for establishing eligibility and reporting enrollment to us based on information from the employer. We process enrollment as reported by the Exchange.

This EOC includes Pediatric Benefits.

Eligibility Requirements for Pediatric Benefits

Pediatric Enrollees eligible for Pediatric Benefits are:

- an Employee to age 19; and/or
- an Employee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, step-children, adopted children, children placed for adoption and children of a Spouse.

Enrollment

You may be required to contribute towards the cost of coverage for Pediatric Enrollees. The Exchange is responsible for establishing an Enrollee's Effective Date for enrollment.

Employees may enroll for coverage during the Open Enrollment Period or due to a Qualifying Status Change.

Dependents on active military duty are not eligible.

CANCELLATION OF COVERAGE BY YOU

The [Eligible Employee/Primary Enrollee] has the right to terminate coverage under this Plan by sending Delta Dental or the Exchange written notice of intent to terminate. The effective date of a requested termination will be at least 14 days from the date of Delta Dental's receipt of the request for termination. Delta Dental will notify the Contractholder of any requests for

termination received from Eligible Employees. If coverage is terminated because the Enrollee is covered by Medicaid, the last day of coverage with Delta Dental is the day before the new coverage is effective.

An Enrollee loses eligibility when the [Eligible Employee/Primary Enrollee] is no longer reported eligible by the Exchange or eligible under the terms of the Contract. If termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month of termination. If termination is due to age, termination is effective the last day of the calendar year the Enrollee loses eligibility.

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE BY DELTA DENTAL

Cancellation of Enrollment Due to Non-Payment of Premium

Grace Period

We may cancel the Contract after written notice to the Contractholder if Premiums, or a portion of Premiums, are not paid by the due date after being Billed for the Charge. We will provide a [Notice of Start of Grace Period][notice] to the Contractholder stating a payment delinquency has triggered a Grace Period of [30] days starting the day the [Notice of Start of Grace Period][notice] is dated. The Contractholder will promptly send or make available a copy of this notice to you. Your coverage will continue in effect during the Grace Period.

You are financially responsible for any and all Premiums, any Copayments, coinsurance or deductible amounts, including those incurred for services received during the Grace Period.

A [Notice of End of Coverage][notice] will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes the following statement: “To learn about new coverage or whether your coverage can be re-instated, contact Delta Dental of California at [deltadentalins.com]. The Contractholder will promptly send or make available a copy of this notice to you. If you lose coverage, you may be financially responsible for the payment of claims incurred.

Cancellation of Enrollment Other Than Non-Payment of Premium

For cancellation, rescission and non-renewal other than for non-payment of Premium, we will provide the Contractholder with a [Notice of Cancellation, Rescission or Nonrenewal]. The Contractholder will promptly send or make available a copy of this notice you. A [Notice of End of Coverage] will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes:

- The following statement: “To learn about new coverage or whether your coverage can be re-instated, contact Delta Dental of California at [deltadentalins.com].”
- Notice as to the availability of the right to request completion of covered services.

If the Contract is terminated for any cause, we are not required to preauthorize services beyond the termination date or to pay for services provided after the termination date, except for services begun while the Contract was in effect or if you have a cancellation grievance pending for reasons other than non-payment of Premium submitted prior to the effective date of your cancellation, renewal or rescission of coverage. Please refer to the provisions below regarding your right to submit a grievance and continuation of benefits.

Right to Submit Grievance Regarding Cancellation, Rescission or Non-Renewal of Your Plan Enrollment, Subscription or Contract

If you believe your enrollment has been, or will be, improperly cancelled, rescinded or not renewed you have at least 180 days from the date of the notice you allege to be improper to submit a grievance to us and/or to the Department of Managed Health Care (“DMHC”). We will provide you and the DMHC with a disposition or pending status on your grievance within three (3) calendar days of our receipt of your grievance.

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal, for reasons other than non-payment of Premium, we will continue to provide coverage while the grievance is pending with us or the DMHC. During the period of continued coverage, you are responsible for paying Premiums and any and all Copayments, coinsurance, or deductible amounts as required under your coverage.

OPTION 1 – YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

You may submit online at deltadentalins.com, or call **888-282-8528** or write to:

Delta Dental of California
[Attn: Correspondence Department
P.O. Box 997330
Sacramento, CA 95899-7330]

You may want to submit your grievance to Delta Dental first if you believe your cancellation, rescission, or non-renewal is the result of a mistake. Grievances should be submitted as soon as possible.

We will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from us within three (3) calendar days, or if you are not satisfied in any way with our response, you may submit a grievance to the DMHC as detailed under Option 2 below.

OPTION 2 – YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DMHC.

You may submit a grievance to the DMHC without first submitting it to Delta Dental or after you have received our decision on your grievance. Grievances may be submitted to the DMHC online at **www.Healthhelp.ca.gov** or by mailing your written grievance to:

Help Center
Department of Managed Health Care
[980 Ninth Street, Suite 500
Sacramento, CA 95814-2725]

You may contact the DMHC for more information on filing a grievance at:

Phone: [1-888-466-2219]
TDD: [1-877-688-9891]
Fax: [1-916-255-5241]

Reinstatement of Coverage

If you submit a grievance for the cancellation, rescission or non-renewal of coverage, including cancellation due to non-payment of Premium, and it is determined that the cancellation, rescission or non-renewal is improper, your coverage may be reinstated retroactive to the date of cancellation, rescission or non-renewal. The Contractholder or you, if you are responsible for paying your Premium, may be responsible for the payment of any and all outstanding Premium payments accrued from the effective date of the cancellation, rescission or non-renewal before reinstatement. Any outstanding Premium must be paid prior to reinstatement.

Strike, Lay-off and Leave of Absence

Enrollees will not be covered for any dental services received while the Employee is on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume after the Employee returns to work provided the Contractholder submits a request to the Exchange that coverage be reactivated. Benefits for Enrollees will resume as follows:

- If coverage is reactivated in the same Contract Year, coverage will resume as if the Employee was never gone.
- If coverage is reactivated in a different Contract Year, any Out-of-Pocket Maximum applicable to your Benefits will start over.

- If the Employee is re-hired within the same Contract Year, coverage will resume as if the Employee was never gone.

*Coverage for Enrollees is not affected if the Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Employee is currently paying any part of the Premium, they may choose to continue coverage. If the Employee does not continue coverage during the leave, they can resume coverage for Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act of 1993 does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Continued Coverage Under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if the Employee is covered by the Contract on the date the Employee's USERRA leave of absence begins, dental coverage for the Employee and any covered dependents may continue. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins; or
- the date the Employee fails to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the "Consolidated Omnibus Budget Reconciliation Act of 1985") provides a way for the Employee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

[Continuation of Coverage Under Cal-COBRA

Dependent Enrollees who lose employer-sponsored group health coverage ("Qualified Beneficiary") to continue coverage for a period of time. We agree to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- continuation of coverage is required to be offered under Cal-COBRA;
- Contractholder notifies us in writing of any Employee who has a qualifying event within 30 days of the qualifying event;
- Contractholder notifies us in writing of any Qualified Beneficiaries currently receiving continuation of coverage from a previous plan;
- Contractholder notifies Qualified Beneficiaries currently receiving continuation coverage under another plan of the Qualified Beneficiary's ability to continue coverage under Delta Dental's new group benefit plan for the balance of the period the Qualified Beneficiary is eligible for continuation coverage. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later;
- Contractholder notifies the Qualified Beneficiary if of the ability to elect coverage under the Contractholder's new dental plan, if Contractholder terminates Contract and replaces Delta Dental with another dental plan. Said notice shall be provided the later of 30 days prior to termination of Delta Dental's coverage or when the Enrollees are notified;
- Qualified Beneficiary requests the continuation of coverage within the time frame allowed;
- we receive the required Premium for the continued coverage; and
- the Contract stays in force.

We do not assume any of the obligations required by Cal-COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under Cal-COBRA.]

OVERVIEW OF DENTAL BENEFITS

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.

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

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits through a convenient network of Contract Dentists within the Delta Dental Service Area in the state of California. The [DeltaCare USA Network] is comprised of established dental professionals who are screened to ensure that our standards of quality, access and safety are maintained. The DeltaCare USA network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment(s) for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

The DeltaCare USA Plan provides the Benefits described in the Schedules that are a part of this EOC. Benefits are only available in the state of California. Services are performed as deemed appropriate by your assigned Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this EOC. Copayments are paid directly to the Dentist who provides treatment.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA dentist contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, if you receive treatment from an Out-of-Network Dentist and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the "Emergency Dental Services," "Urgent Dental Services" and "Specialist Services" provisions in this EOC.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about your dental coverage options, you may call Customer Care at **888-282-8528**. To fully understand your coverage, you may wish to carefully review this EOC.

Coordination of Benefits

We coordinate the Benefits under this EOC with your benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other plans. If this plan is the "primary" plan, we will not reduce Benefits, but if this plan is the "secondary" plan, we determine Benefits after those of the primary plan and will pay the lesser of the amount that we would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under this EOC.

How do we determine which Plan is the "primary" plan?

(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.

(2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent; except that if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a) secondary to the plan covering the insured person as a dependent; and

b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

a) First, the benefits of a plan covering the insured person as an employee (or as that insured person's dependent).

b) Second, the benefits under the continuation coverage.

c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (7) is ignored.

(8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental only plan.

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

Delta Dental will provide Contract Dentists to Enrollees at convenient locations during the Contract Term. Upon enrollment, Delta Dental will assign the Enrollee to a Contract Dentist facility. The Primary Enrollee may request changes to the assigned Contract Dentist facility by contacting Customer Care at **888-282-8528**. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. When searching online for a Contract Dentist, select the [DeltaCare USA Network] to ensure you have the list of Contract Dentists applicable to your plan. 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 this Plan; or 3) an assigned facility requests, for good cause, that the Enrollee 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; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits shall be rendered at the Contract Dentist facility assigned to the Enrollee. Delta Dental shall have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Dental Services or Specialist Services referred by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Copayment(s). A Contract Dentist may provide Specialist Services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

If your assigned Contract Dentist facility terminates participation in this Plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, your Contract Dentist is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental shall give written notice to the Enrollee, within a reasonable time, of any termination or breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Plan with your terminated Contract Dentist for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Plan with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact our Customer Care at **888-282-8528.** You may also contact us to request a copy of Delta Dental's *Continuity of Care Policy*. Delta Dental is not required to continue care with the Dentist if you are not eligible under this Plan or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

Emergency Dental Services are palliative relief, controlling of dental pain, and/or stabilizing the patient's condition. The Enrollee's assigned Contract Dentist facility maintains a 24 hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, the Enrollee can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this Plan.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee believes that they may need Urgent Dental Services, the Enrollee can call their assigned Contract Dentist.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, we cover medically necessary dental services when prompt attention is required from an Out-of-Network Dentist, if all of the following are true:

- The Enrollee receives Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered by this Plan if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their assigned Contract Dentist. The Enrollee is responsible for any Copayment(s) for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, the Enrollee will have access to their assigned Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if they are experiencing an Emergency Dental Condition.

If the Enrollee calls our Customer Care, a representative will answer their call within 10 minutes during normal business hours.

Language Interpretation Services

We offer qualified interpretation services to limited-English proficient Enrollees at no cost to the Enrollee, at all points of contact in any modern language, including when an Enrollee is accompanied by a family member or friend who can provide language interpretation services. Should an Enrollee need language interpretation services with their DeltaCare USA Dentist, they may call Customer Care at **888-282-8528** for assistance.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry must be: 1) referred by your assigned Contract Dentist and 2) authorized by us. You pay the specified Copayment(s). (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered by this Plan.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits available to you under this Plan.

Claims for Reimbursement

Claims for covered Emergency Dental Services, Urgent Dental Services and 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 dental claim submissions must be received within one (1) year of the treatment date. The address for dental claim submissions is: Delta Dental Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment(s) paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at the toll-free telephone number shown in this EOC.

Processing Policies

The dental care guidelines for this Plan explain to Contract Dentists what services are covered under the Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of this Plan are provided, subject to any Copayment(s). If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Customer Care at **888-282-8528** for information about this Plan's dental care guidelines.

A Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving an Emergency Dental Condition will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and

timeframes for second opinion Authorizations, contact Customer Care at **888-282-8528** or write to us.

Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network Dentist if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with us or with the Department. Refer to the "Enrollee Claims Complaint Procedure" section in this EOC for more information.

Special Health Care Need

If you believe you have a Special Health Care Need, you should contact Customer Care at **888-282-8528**. We will confirm that a Special Health Care Need exists and what arrangements can be made to assist you in obtaining such Benefits. We will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, contact Customer Care at **888-282-8528**.

ENROLLEE CLAIMS COMPLAINT PROCEDURE

Delta Dental, or the Administrator, will notify the Enrollee if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for the denial. If you have a complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator or the quality of dental services performed by a Contract Dentist, you may call Customer Care at **888-282-8528**, submit a [**DeltaCare USA Enrollee Grievance Form**] online or mail the complaint to:

Delta Dental
Quality Management Department
P.O. Box 6050
Artesia, CA 90702-6050

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

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by the Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within five (5) calendar days of the receipt of any complaint, the quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of receipt and plan contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 calendar days of receipt of a complaint.

Our grievance system ensures all plan Enrollees have access to and can fully participate in our grievance process by providing assistance for those with limited English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as

access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If you are in need of these services and/or have questions about our grievance process, please contact Customer Care at **888-282-8528** and/or visit our website at **deltadentalins.com** to complete and submit a [**DeltaCare USA Enrollee Grievance Form**].

Our grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the Enrollee's dissatisfaction. We do not discriminate against any Enrollee (including cancellation of the Contract) on the grounds that the complainant filed a grievance.

Enrollees may file a complaint with the DMHC after completing our grievance process or if they have been involved in our grievance process for more than 30 days. Enrollees may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to their health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, we will provide the Enrollee with written statement on the disposition or pending status of the grievance no later than three (3) calendar days from the date of receipt of the grievance. You may file a complaint with the DMHC immediately if you are experiencing an Emergency Dental Condition.

If the group health plan is subject to ERISA, you may contact the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") for further review of the claim or if you have questions about your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Complaints Involving an Adverse Benefit Determination

If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, we will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request. If an Enrollee believes that the decision was denied on the grounds that it was not medically necessary, the Enrollee may contact the DMHC to determine if the decision is eligible for an independent medical review. Enrollees will not be discriminated against in any way by Delta Dental for filing a grievance.

California law requires that Delta Dental provide you with the following information:

The CA Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **888-282-8528** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment Program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to:

Delta Dental of California
Customer Care
P.O. Box 997330
Sacramento, CA 95899-7330

Severability

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

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract and/or this EOC, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract and/or this EOC, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required.

Conformity with Applicable Laws

All legal questions about the Contract and/or this EOC will be governed by the state of California where the Contract was entered into and is to be performed. Any part of the Contract and/or this EOC that conflicts with the laws of California, specifically Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Division 1, of Title 28 of the California Code of Regulations or federal law, is hereby amended to conform to the minimum requirements of such laws. Any provision required to be in the Contract by either of the above shall bind Delta Dental whether or not provided in the Contract.

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under the Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides 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)
- Provides 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 Delta Dental's Customer Care at **888-282-8528**.

If you believe that Delta Dental has 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 Care representative or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: **888-282-8528**
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, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

2021 Dental Standard Benefit Plan Design

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.		**Children's Dental Plan** **Copay Plan** **Pediatric Dental EHB** **Up to Age 19**
Actuarial Value		85.0%
		In Network
Individual Deductible		None
Family Deductible (Two or more children)		Not Applicable
Individual Out of Pocket Maximum		$350
Family Out of Pocket Maximum (Two or More Children)		$700
Office Copay		$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))		None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None
Procedure Category	**Service Type**	**Member Cost Share**
Diagnostic & Preventive	Oral Exam	No charge
	Preventive - Cleaning	No charge
	Preventive - X-ray	No charge
	Sealants per Tooth	No charge
	Topical Fluoride Application	No charge
	Space Maintainers - Fixed	No charge
Basic Services	Restorative Procedures	See 2021 Dental Copay Schedule
	Periodontal Maintenance Services	
Major Services	Periodontics (other than maintenance)	See 2021 Dental Copay Schedule
	Endodontics	
	Crowns and Casts	
	Prosthodontics	
	Oral Surgery	
Orthodontia	Medically Necessary Orthodontia	$350

SCHEDULE A

Description of Benefits and Copayments for Pediatric Enrollees (Under Age 19)

[DeltaCare® USA

Children's Dental HMO

For Small Businesses]

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-2020 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation. Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Under Age 19):

Pediatric Enrollee.....	**$350.00** each Contract Year
Multiple Pediatric Enrollees.....	**$700.00** each Contract Year

OOPM applies only to Essential Health Benefits ("EHB") for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Pediatric Benefits under this Plan during a Contract Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments, or that are not covered under the Contract, 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 on the Contract, the financial obligation for Pediatric Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets their OOPM, they will have no further payment for the remainder of the Contract Year for Pediatric Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Contract Year for Pediatric Benefits.

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

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Enrollee per Contract Dentist*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 per 3 months, not to exceed 12 per 12 month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0190	Screening of a patient	Not Covered	
D0191	Assessment of a patient	Not Covered	
D0210	Intraoral - complete series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0351	3D photographic image	No charge	*1 per date of service*
D0419	Assessment of salivary flow by measurement	Not Covered	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Interim caries arresting medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D1526	Space maintainer - removable - bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable - bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2542	Onlay - metallic - two surfaces	Not Covered	
D2543	Onlay - metallic - three surfaces	Not Covered	
D2544	Onlay - metallic - four or more surfaces	Not Covered	
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	
D2662	Onlay - resin-based composite - two surfaces	Not Covered	
D2663	Onlay - resin-based composite - three surfaces	Not Covered	
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2720	Crown - resin with high noble metal	Not Covered	
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2722	Crown - resin with noble metal	Not Covered	
D2740	Crown - porcelain/ceramic	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2750	Crown - porcelain fused to high noble metal	Not Covered	
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2752	Crown - porcelain fused to noble metal	Not Covered	
D2753	Crown - porcelain fused to titanium and titanium alloys	Not Covered	
D2780	Crown - 3/4 cast high noble metal	Not Covered	
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2782	Crown - 3/4 cast noble metal	Not Covered	
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2790	Crown - full cast high noble metal	Not Covered	
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2792	Crown - full cast noble metal	Not Covered	
D2794	Crown - titanium and titanium alloys	Not Covered	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration - primary dentition	$30	*1 per tooth per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D3348	Retreatment of previous root canal therapy - molar	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	
D3410	Apicoectomy - anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3427	Periradicular surgery without apicoectomy	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3430	Retrograde filling - per root	$90	
D3450	Root amputation - per root	Not Covered	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3920	Hemisection (including any root removal), not including root canal therapy	Not Covered	
D3950	Canal preparation and fitting of preformed dowel or post	Not Covered	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not Covered	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not Covered	
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	Not Covered	
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	Not Covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	
D4266	Guided tissue regeneration - resorbable barrier, per site	Not Covered	
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not Covered	
D4270	Pedicle soft tissue graft procedure	Not Covered	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered	
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	Not Covered	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
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 Covered	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	Not Covered	
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	Not Covered	
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant	Not Covered	
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant	Not Covered	
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	
D5710	Rebase complete maxillary denture	Not Covered	
D5711	Rebase complete mandibular denture	Not Covered	
D5720	Rebase maxillary partial denture	Not Covered	
D5721	Rebase mandibular partial denture	Not Covered	
D5730	Reline complete maxillary denture (chairside)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5731	Reline complete mandibular denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture - complete maxillary	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular	$300	*1 per 60 months*
D5876	Add metal substructure to acrylic full denture (per arch)	Not Covered	
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6011	Second stage implant surgery	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6052	Semi-precision attachment abutment	$350	*A Benefit only under exceptional medical conditions*
D6055	Connecting bar - implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions*
D6056	Prefabricated abutment - includes modification and placement	$135	*A Benefit only under exceptional medical conditions*
D6057	Custom fabricated abutment - includes placement	$180	*A Benefit only under exceptional medical conditions*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions*
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6067	Implant supported crown - high noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric 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	$30	*A Benefit only under exceptional medical conditions*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Provisional implant crown	$300	*A Benefit only under exceptional medical conditions*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions*
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Implant removal, by report	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant /abutment supported removable denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6111	Implant /abutment supported removable denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6112	Implant /abutment supported removable denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6113	Implant /abutment supported removable denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6114	Implant /abutment supported fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6115	Implant /abutment supported fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6116	Implant /abutment supported fixed denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6117	Implant /abutment supported fixed denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6205	Pontic - indirect resin based composite	Not Covered	
D6210	Pontic - cast high noble metal	Not Covered	
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6212	Pontic - cast noble metal	Not Covered	
D6214	Pontic - titanium and titanium alloys	Not Covered	
D6240	Pontic - porcelain fused to high noble metal	Not Covered	
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6242	Pontic - porcelain fused to noble metal	Not Covered	
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not Covered	
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6250	Pontic - resin with high noble metal	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6252	Pontic - resin with noble metal	Not Covered	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not Covered	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	
D6549	Retainer – for resin bonded fixed prosthesis	Not Covered	
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not Covered	
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not Covered	
D6610	Retainer onlay - cast high noble metal, two surfaces	Not Covered	
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not Covered	
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not Covered	
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not Covered	
D6614	Retainer onlay - cast noble metal, two surfaces	Not Covered	
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not Covered	
D6634	Retainer onlay - titanium	Not Covered	
D6710	Retainer crown - indirect resin based composite	Not Covered	
D6720	Retainer crown - resin with high noble metal	Not Covered	
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6722	Retainer crown - resin with noble metal	Not Covered	
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6782	Retainer crown - 3/4 cast noble metal	Not Covered	
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6794	Retainer crown - titanium and titanium alloys	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue-soft	$110	*3 per date of service*
D7287	Exfoliative cytological sample collection	Not Covered	
D7288	Brush biopsy - transepithelial sample collection	Not Covered	
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or LeFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Surgical sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Copayment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Copayment applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.			
- Refer to Schedule B for additional information on medically necessary orthodontics.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition		*1 per Enrollee per phase of treatment*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance - maxillary		*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance - mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer - maxillary	$350	*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer - mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*
D8704	Replacement of lost or broken retainer - mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9222	Deep sedation/general anesthesia - first 15 minutes	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9450	Case presentation, detailed and extensive treatment planning	Not Covered	
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9942	Repair and/or reline of occlusal guard	Not Covered	
D9943	Occlusal guard adjustment	Not Covered	
D9944	Occlusal guard – hard appliance, full arch	Not Covered	
D9945	Occlusal guard – soft appliance, full arch	Not Covered	
D9946	Occlusal guard – hard appliance, partial arch	Not Covered	
D9950	Occlusion analysis - mounted case	$120	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	Not Covered	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Not Covered	
D9997	Dental case management - patients with special health care needs	No charge	
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

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, 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.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. 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(s) for the covered procedure.

Additional Endnotes to Covered California's 2021 Dental Standard Benefit Plan Designs

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

1. In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
2. In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum
3. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") Benefit.

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

DeltaCare USA
Children's Dental HMO
for Small Businesses

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments for Pediatric Enrollees*. Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown [D2390 and covered codes only between D2710-D2791] is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.
4. The replacement of an existing crown [D2390 and covered codes only between D2710-D2791], fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791], or a removable full [D5110, D5120] or partial denture [covered codes only between D5211-D5214, D5221-D5224] is covered when:
   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
   b. Either of the following:
      - the existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, **or**
      - if an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
5. Coverage for the placement of a fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or removable partial denture [covered codes only between D5211-D5214, D5221-D5224]:
   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, **or**
      - Each abutment tooth to be crowned meets Limitation #3.
   b. Removable partial denture:
      - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
6. Excision of the frenum [D7960] is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
7. A new removable partial [covered codes only between D5211-D5214, D5221-D5224] or complete [D5110-D5140] or covered immediate denture [D5130, D5140] includes after delivery adjustments and tissue conditioning at no additional cost 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 denture was originally delivered.
8. Immediate dentures [D5130, D5140, D5221–D5224] are covered when one or more of the following conditions are present:

a. extensive or rampant caries are exhibited in the radiographs, **or**
b. severe periodontal involvement indicated, **or**
c. numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

9. Maxillofacial prosthetic services [covered codes only between D5911-D5999] for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

10. All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior authorization for medically necessary procedures.

11. Implant services [covered codes only between D6010-D6199] are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
    a. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.
    c. skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

12. Temporomandibular joint dysfunction ("TMJ") procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.

13. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

14. Deep sedation/general anesthesia [D9222, D9223] or intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments for Pediatric Enrollees*, except as required by state or federal law.

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

3. Lost or theft of full or partial dentures [covered codes only between D5110-D5140, D5211-D5214, D5221-D5224], space maintainers [D1510–D1575], crowns [D2390 and covered codes only between D2710–D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] or other appliances.

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

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

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

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 888-282-8528.

10. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120–D0999], for non-covered Benefits.

11. Single tooth implants [covered codes only between D6000–D6199].

12. Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative [covered codes only between D2140-D2999] procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures [covered codes only between D5211-5214, D5221-D5224] are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], periodontal splinting [D4320-D4321], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these [covered codes only between D2710-D2791, D6211-D6245, D6251, D6721-D6791] is considered to be full mouth reconstruction under this Plan. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.

17. Porcelain denture teeth, or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.

18. Extraction of teeth [D7111, D7140, D7210, D7220-D7240, D7241, D7250], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

19. TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6721-D6791], orthodontia [covered codes only between D8000–D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.

20. Vestibuloplasty/ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.

21. Deep sedation/general anesthesia [D9222, D9223] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia [D9239, D9243].

22. Intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia [D9222, D9223].

23. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.

24. Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999].

25. Orthodontic treatment [covered codes only between D8000–D8999] must be provided by a licensed dentist. Self-administered orthodontics are not covered.

26. The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered benefit.

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment [D8080] requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation ("HLD") Index California Modification Score Sheet Form and pre-treatment diagnostic casts [D0470]. Comprehensive orthodontic treatment [D8080]:
   a. is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b. may start at birth for patients with a cleft palate or craniofacial anomaly.
2. Removable appliance therapy [D8210] or fixed appliance therapy [D8220] is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.
3. The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0351]. Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment examination.
4. The number of covered periodic orthodontic treatment visits [D8670] and length of covered active orthodontics is limited to a maximum of up to:
   a. handicapping malocclusion - eight (8) quarterly visits;
   b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
   c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
   d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
   e. facial growth management - four (4) quarterly visits for treatment of primary dentition;
   f. facial growth management - five (5) quarterly visits for treatment of mixed dentition;
   g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.
5. Orthodontic retention [D8680] is a separate Benefit after the completion of covered comprehensive orthodontic treatment [D8080] which:
   a. includes removal of appliances and the construction and place of retainer(s) [D8680] and
   b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

   An adjustment of an orthodontic retainer is included in the fee for the retainer for the first six months after delivery.
6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment [covered codes only between D8000–D8999]. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
   a. will not be entitled to a refund of any amounts previously paid; and
   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment [covered codes only between D8000–D8999], the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:
   a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
   b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

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

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Plan

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

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

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