DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

COVERED CALIFORNIA

Delta Dental PPO™

Children's Dental PPO
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
800-471-0176
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.

TABLE OF CONTENTS

INTRODUCTION 1

DEFINITIONS 2

ELIGIBILITY AND ENROLLMENT 4

CANCELLATION OF COVERAGE BY YOU 5

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE BY DELTA DENTAL 5

OVERVIEW OF DENTAL BENEFITS 8

SELECTING YOUR PROVIDER 11

GRIEVANCES AND APPEALS 14

GENERAL PROVISIONS 16

ATTACHMENTS:

ATTACHMENT A – DEDUCTIBLES, MAXIMUMS, CONTRACT BENEFIT LEVELS AND ENROLLEE COINSURANCES

ATTACHMENT B – SERVICES, LIMITATIONS AND EXCLUSIONS

ATTACHMENT C – INFORMATION CONCERNING BENEFITS FOR DELTA DENTAL PPO

INTRODUCTION

We are pleased to welcome you to the Delta Dental PPO 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 and administered by Delta Dental.

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 the Dentist but to see one on a regular basis.

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

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

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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 under this EOC. "We," "us" and "our" always refer to Delta Dental. In addition, please read the "Definitions" section which will explain any words with special or technical meanings. Persons with Special Health Care Needs should read the section entitled "Special Health Care Need."

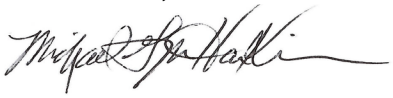
Identification Number - The Enrollee should provide their identification ("ID") number to their Provider whenever dental services are received. The Enrollee ID number should be included on all claims submitted for payment. ID cards are not required but may be obtained by visiting our website at deltadentalins.com.

This EOC is *not* a Summary Plan Description to meet the requirements of ERISA.

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. Any direct conflict between the Contract and this EOC will be resolved according to the terms which are most favorable to you. A copy of the Contract will be furnished to you upon request.

Contact Us - For more information, please visit our website at deltadentalins.com or call our Customer Care. A Customer Care representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain Benefits, check the status of a claim and assist you in filing a claim. You can access our automated information line at **800-471-0176** to obtain information about your eligibility, Benefits or claim status or to speak to a Customer Care representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

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



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.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Delta Dental will pay for covered dental services under 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).

Claim Form: the standard form used to file a claim, request a Pre-Treatment Estimate or request prior authorization.

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

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

Contract Benefit Level: the percentage of the Maximum Contract Allowance that Delta Dental will pay.

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.

Deductible: a dollar amount that an Enrollee must satisfy covered services before Delta Dental begins paying Benefits.

Delta Dental PPO Contracted Fee ("PPO Provider's Contracted Fee"): the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services under this Plan.

Delta Dental PPO Provider ("PPO Provider"): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for covered services provided under this PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier® Contracted Fee ("Premier Provider's Contracted Fee"): the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services under this Plan.

Delta Dental Premier Provider ("Premier Provider"): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under this Plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

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 Provider, 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 Services: dental screening, examination and evaluation by a Provider or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider 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 Individuals 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.

Enrollee Pays: the Pediatric Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

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 in this Plan 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.

Maximum: the maximum dollar amount we will pay toward the cost of dental care under this Plan.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee; or
- by a Premier Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
- by a Non-Delta Dental Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Delta Dental's administrative guidelines.

[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.

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Contract Year provided a PPO Provider is used. Enrollee coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Premier or Non-Delta Dental Provider even after the out-of-pocket maximum has been met.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this EOC for the services proposed, assuming the person is an eligible Enrollee.

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

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic. Also referred to as a Dentist.

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 (Employee or 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 the Provider's facility because of a physical disability; and 2) the Enrollee's inability to comply with the Provider's instructions during examination or treatment because of physical disability or mental incapacity.

Spouse: a person related to or a domestic partner of an 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.

Submitted Fee: the amount that the Provider bills and enters on a Claim Form for a specific Procedure Code.

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

We, Us and Our: Delta Dental

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 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 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 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 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 on the date reported by the Exchange and you should contact the Exchange to see if special enrollment periods apply.

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

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 **800-471-0176** 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 for the Enrollee as if the Employee was never gone.
- If coverage is reactivated in a different Contract Year, any Deductible, Maximum, Out-of-Pocket Maximum and/or Waiting Period, applicable to your Benefits, will start over.
- If the Employee is rehired within the same Contract Year, coverage will resume for the Enrollee 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, the Employee may choose to continue coverage. If the Employee does not continue coverage during the leave, the Employee can resume coverage 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 their USERRA leave of absence begins, dental coverage will resume for the Employee and their covered Dependent Enrollees. 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

Cal-COBRA (the "California Continuation Benefits Replacement Act") provides a way for you and your 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 dental 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 of the ability to elect coverage under the Contractholder's new dental plan, if Contractholder terminates the 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 YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

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

Benefits, Limitations and Exclusions

This Plan provides Pediatric Benefits using the [Delta Dental PPO™ Network] within the Delta Dental Service Area in the state of California. We will pay Benefits for the types of dental services as described in the Attachments attached to this EOC.

This EOC covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use Dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If you receive dental services from a Provider outside the state of California, that Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract. Limitations and exclusions will be applied for the period a person is enrolled under any Delta Dental program or prior dental care program provided by the Contractholder, subject to receipt of such information from the Contractholder or at the time a claim is submitted.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Plan. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

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.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You may have to satisfy a Deductible before we will pay Benefits. You pay the Enrollee Coinsurance even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled "Selecting Your Provider" for more information.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment showing the services to be provided to you. We will estimate the amount of Benefits payable under this EOC for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before the Enrollee receives any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this EOC when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of this Plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible, if necessary.

Emergency Dental Services

Delta Dental PPO Providers are available 24 hours a day, seven (7) days a week to provide Emergency Dental Services if you are experiencing an Emergency Dental Condition. However, if you are unable to reach a Delta Dental PPO Provider, you may seek treatment from a Provider of your choice. Payment for Emergency Dental Services will be made subject to the provisions described below.

Timely Access to Care

Delta Dental PPO and Premier Providers 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 a PPO or Premier Provider's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if the Enrollee is 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.

Should the Enrollee need interpretation services when scheduling an appointment with any of our PPO or Premier Providers, the Enrollee may call our Customer Care at **800-471-0176** for assistance.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a participating Provider 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 Provider should provide to 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 dental coverage options, you may call our Customer Care at **800-471-0176**. 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 plan 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 the Contract.

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. However, 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 Enrollee 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.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. **This Plan, offered through the Exchange, is a PPO plan and the greatest Benefits – including out-of-pocket savings – occur when you choose a PPO Provider.** We will also pay for services received from dental schools or clinics by students of dentistry, a clinician or instructors who are contracted with Delta Dental. To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment. Review this section for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a PPO Provider

You may access information through our website at deltadentalins.com. You may also call our Customer Care and one of our representatives will assist you. We can provide you with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

The PPO plan potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Costs incurred by the Pediatric Enrollee for covered services with a PPO Provider apply towards the Out-of-Pocket Maximum for Pediatric Benefits.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider; however, the Premier Provider has not agreed to the features of the PPO plan. The amount charged may be above that accepted by PPO Providers and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance and the Enrollee may be balance billed up to the Premier Provider's Contracted Fee.

Costs incurred by the Pediatric Enrollee with a Premier Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services when a Premier Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO and Premier Providers and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance and the Enrollee may be balance billed up to the Provider's Submitted Fee.

Costs incurred by the Pediatric Enrollee with a Non-Delta Dental Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services when a Non-Delta Dental Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

Additional Obligations of PPO and Premier Providers

- The PPO or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- The PPO Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Delta Dental PPO Contracted Fees.
- By statute, our agreement with our PPO and Premier Providers makes sure you will not be responsible to those Providers for any money we owe.

Upon termination of a PPO Provider's contract with Delta Dental, Delta Dental shall be liable for Benefits for the completion of treatment for Single Procedures begun prior to the termination of the agreement. The terminating Provider will complete:

- a partial or full denture for which final impressions have been taken; and
- all work on every tooth upon which work has been started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If for any reason the PPO Provider is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another PPO Provider.

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 PPO Provider if the Enrollee will be materially or adversely affected.

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 Delta Dental Provider, they may call Customer Care at **800-471-0176** for assistance.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

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

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Contract with your terminated Delta Dental Provider for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Contract with your Non-Delta Dental Provider 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 **800-471-0176**. 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 Provider if you are not eligible under this Contract or if Delta Dental cannot reach agreement with the Non-Delta Dental Provider or the terminated Delta Dental Provider on the terms regarding Enrollee care in accordance with California law.

Payment Guidelines

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider file a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If we fail to pay a Non-Delta Dental Dentist, you may be liable to that Provider for the entire cost of services. Delta Dental will reimburse you for any portion of the Provider's fee that is covered by this Plan.

If the payment is denied because your PPO Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO or Premier Provider that you were covered under this Plan at the time you received the service, you may be responsible for the cost of that service.

If you need more information concerning how Providers are reimbursed under the Contract, you may call our Customer Care toll-free at **800-471-0176**.

Provider Relationships

The Primary Enrollee and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

Second Opinion

Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefit determination in response to a request for a Pre-Treatment Estimate. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of the care provided. Delta Dental will notify the Enrollee and the treating Provider when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, we will pay for all charges.

Enrollees may otherwise obtain a second opinion about treatment from any Dentist they choose and claims for the examination may be submitted to Delta Dental for payment. Delta Dental will pay such claims in accordance with the Benefits of this Plan.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact our Customer Care at **800-471-0176**. We will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. We will not be responsible for the failure of any Provider to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Provider.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Care at **800-471-0176**.

GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Care. You can also email questions by accessing the "Contact Us" section of our website at **deltadentalins.com**.

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, operations of Delta Dental or the quality of care for dental services performed by a Provider may be directed in writing to us, by calling us at **800-471-0176** or submitting a [**Delta Dental PPO Enrollee Grievance Form**] online.

When you write, please include the name of Enrollee's name, ID number and telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason for the denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review in writing to Delta Dental giving reasons why you believe the denial was wrong. You may also ask Delta Dental to examine any additional information you include that may support your grievance.

"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 Enrollee or the Enrollee's

representative. Where this Plan is unable to distinguish between a grievance and an inquiry, it shall 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.

Send your grievance to us at:

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

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 **800-471-0176** and/or visit our website at **deltadentalins.com** to complete and submit a [**Delta Dental PPO 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 on the grounds that the complainant filed a grievance.

Enrollees may file a complaint with the DMHC after completing Delta Dental's grievance process or if they have been involved in Delta Dental's 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, Delta Dental 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.

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 Policy, Delta Dental shall 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 **800-471-0176** 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.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 ("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 the 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

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 communications 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.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider or from hospitals in which a Provider's care is provided, such information and records relating to the treatment provided to you as may be required to administer the claim. Examination may be required by a dental consultant retained by us in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address in the "Written Notice of Claim/Proof of Loss" section.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated). A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

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

Time of Payment

Claims payable under this Plan for any loss other than loss for which the Contract provides a periodic payment will be processed no later than 30 days after written proof of loss is received in the form required by the terms of the Contract and/or this EOC. We will notify you and your Provider of any additional information needed to process the claim within this 30-day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a PPO or Premier Provider will be made directly to that Provider. Any other payments provided by the Contract and/or this EOC will be made to you. All Benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the minor's parent, guardian or other person supporting the minor.

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. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

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.

Holding Company

Delta Dental is a member of the insurance holding company system of Delta Dental of California (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. Delta Dental is a party to some of these service agreements. It is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

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 organ and tissue provides many societal benefits. Organ and tissue donation allow 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 to your physician. Organ donation begins at the hospital when a person 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 **800-471-0176**.

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: **800-471-0176**
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.

Attachment A
Deductibles, Maximums, Contract Benefit Levels and Enrollee Coinsurances

Summary of Benefits and Coverage		Children's Dental Plan	
		Coinsurance Plan	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental Essential Health Benefits	
		Up to Age 19	
Actuarial Value		**86.2%**	**86.2%**
		In-Network: Delta Dental PPO[1]	**Out-of- Network: Non-Delta Dental PPO[1]**
Individual Deductible each Contract Year[2]		$75	$75
Family Deductible each Contract Year (Two or more children)[2]		$150	$150
Individual Out of Pocket Maximum each Contract Year[3]		$350	None
Family Out of Pocket Maximum each Contract Year (Two or More Children)[3]		$700	None
Office Copay		$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)		None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the Contract Year)		None	None
Procedure Category	**Service Type**	**Member Cost Share[4]**	**Member Cost Share[4]**
Diagnostic & Preventive	Oral Exam	No charge	10%
	Preventive - Cleaning	No charge	10%
	Preventive - X-ray	No charge	10%
	Sealants per Tooth	No charge	10%
	Topical Fluoride Application	No charge	10%
	Space Maintainers - Fixed	No charge	10%
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services		
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia[5]	50% Deductible Applies	50% Deductible Applies

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

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

In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network Deductible, if applicable, as well as the family Out-of-Pocket Maximum.

In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network Deductible, if applicable, and do not accumulate to the family Out-of-Pocket Maximum.

Deductible is waived for Diagnostic and Preventive Services.

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

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

[4] Delta Dental will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for covered services. Note: Contract Benefit Levels differ between Delta Dental PPO Providers and Non-Delta Dental PPO Providers. The greatest benefits – including out-of-pocket savings – occur when covered services are received by a Delta Dental PPO Provider. The amount charged to Enrollees for covered services performed by a Non-Delta Dental PPO Provider may be above that accepted by Delta Dental PPO Providers, and Enrollees will be responsible for balance billed amounts.

[5] Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services

Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for Essential Health Benefits and benefits listed below in the Schedule of Covered Services when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment, including x-rays and oral exams.
  - (2) Preventive: cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
  - (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
  - (4) Specialist Consultations: opinion or advice requested by a general dentist.

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

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

- **Note on Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.**
  Administration of this plan design must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

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

Schedule of Covered Services

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

Procedure Code	Procedure Description and Limitations
<u>Diagnostic and Preventive Services</u>	
D0120	Periodic oral evaluation - established patient: once every 6 months per provider
D0140	Limited oral evaluation - problem focused: once per patient per provider
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient: once per patient per provider
D0160	Detailed and extensive oral evaluation - problem focused, by report: once per patient per provider
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit): 6 in 3 months, not to exceed 12 in 12 months
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images: once per provider every 36 months
D0220	Intraoral - periapical first radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0230	Intraoral - periapical each additional radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0240	Intraoral - occlusal radiographic image: maximum of 2 in 6 months per provider
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector: once per date of service
D0251	Extra-oral posterior dental radiographic image: 4 per date of service
D0270	Bitewing - single radiographic image: once per date of service
D0272	Bitewings - two radiographic images: once every 6 months per provider
D0273	Bitewings - three radiographic image
D0274	Bitewings - four radiographic images: once every 6 months per provider, age 10 and older
D0277	Vertical bitewings - 7 to 8 radiographic images: maximum of 4
D0310	Sialography

D0320	Temporomandibular joint arthrogram, including injection: maximum of 3 per date of service
D0322	Tomographic survey: twice in 12 months per provider
D0330	Panoramic radiographic image: once in 36 months per provider
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis: twice in 12 months per provider
D0350	2D oral/facial photographic image obtaine d intra-orally or extra-orally: maximum of 4 per date of service
D0351	3D photographic image: once per date of service
D0460	Pulp vitality tests
D0470	Diagnostic casts: once per provider
D0502	Other oral patholog y procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk: one procedure (D0601, D0602, D0603) every 36 months per provider
D0602	Caries risk assessment and documentation, with a finding of moderate risk: one procedure (D0601, D0602, D0603) every 36 months per provider
D0603	Caries risk assessment and documentation, with a finding of high risk: one procedure (D0601, D0602, D0603) every 36 months per provider
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult: once every 6 months
D1120	Prophylaxis - child: once every 6 months
D1206	Topical application of fluoride varn ish: once every 6 months and frequency limitation applies towards D1208
D1208	Topical application of fluoride – ex cluding varnish: once every 6 months and frequency limitation applies towards D1206
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1330	Oral hygiene instructions
D1351	Sealant - per tooth: once per permanent molar every 36 months per provider if they are without caries (decay) or restorations on the occlusal surface.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth: once per tooth every 36 months per provider
D1353	Sealant repair - per tooth
D1354	Interim caries arresting medicament a pplication - per tooth: once every 6 months
D1510	Space maintainer - fixed - unilateral- per quadrant: once per quadrant per patient through age 17
D1516	Space maintainer - fixed – bilateral, maxillary: once per arch per patient through age 17
D1517	Space maintainer - fixed – bilateral, ma ndibular: once per arch per patient through age 17
D1520	Space maintainer - removable - unilateral- per quadrant: once per quadrant per patient through age 17
D1526	Space maintainer - removable – bilateral, maxillary: once per arch per patient through age 17
D1527	Space maintainer - removable – bilate ral, mandibular: once per arch per patient through age 17
D1551	Re-cement or re-bond bilateral space main tainer – maxillary: once per provider per quadrant or arch through age 17
D1552	Re-cement or re-bond bilateral space maintainer - mandibular: once per provider per quadrant or arch through age 17
D1553	Re-cement or re-bond bilateral space ma intainer - per quadrant: once per provider per quadrant or arch through age 17

D1556	Removal of fixed unilateral space maintainer - per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer - mandibular
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant: once per quadrant per lifetime; under age 9
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation: once every 6 months
D9310	Consultation - diagnostic service prov ided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medi cal health care professional
D9997	Dental case management - patients with special health care needs
Basic Services	
D2140	Amalgam - one surface, primary or perman ent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2150	Amalgam - two surfaces, primary or pe rmanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2160	Amalgam - three surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2161	Amalgam - four or more surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2330	Resin-based composite - one surface, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior): once in 12 months for primary teeth , once in 36 months for permanent teeth
D2390	Resin-based composite crown, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2391	Resin-based composite - one surface, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2392	Resin-based composite - two surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2393	Resin-based composite - three surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration: once in 12 months per provider
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core: performed in conjunction with recementation of existing or new crown and is not separately payable
D2920	Re-cement or re-bond crown
D2921	Reattachment of tooth fragment, incisal edge or cusp: once in 12 months.
D2929	Prefabricated porcelain/ceramic crow n – primary tooth: once in 12 months
D2930	Prefabricated stainless steel crown - primary tooth: once in 12 months
D2931	Prefabricated stainless steel crown - permanent tooth; once in 36 months
D2932	Prefabricated resin crown: once in 12 mo nths for primary teeth, once in 36 months for permanent teeth
D2933	Prefabricated stainless steel crown with resin window: once in 12 months for primary teeth, once in 36 months for permanent teeth

D2940	Protective restoration: once per tooth in 6 months per provider
D2941	Interim therapeutic restoration - primary dentition: once per tooth in 6 months per provider
D2949	Restorative foundation fo r an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration: once per tooth for permanent teeth
D2952	Post and core in addition to crown, indirectly fabricated: once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown: once per tooth
D2955	Post removal
D2957	Each additional prefabricated post - same tooth
D2971	Additional procedures to construct new crown under existing partial denture framework
D2980	Crown repair necessitated by restorative material failure
D2999	Unspecified restorative procedure, by report
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal maintenance: once in a calendar quarter and only in the 24 months following the last scaling and root planing, age 13+
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure: once per tooth in 24 months
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D9110	Palliative (emergency) treatment of dental pain - minor procedure: once per date of service per provider regardless of the number of teeth and/or areas treated
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures: once per date of service per provider
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each 15 minute increment
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248	Non-intravenous conscious sedation: once per date of service
D9410	House/extended care facility call: once per patient per date of service
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed: once per date of service per provider
D9440	Office visit - after regula rly scheduled hours: once per date of service per provider
D9610	Therapeutic parenteral drug, single administration: maximum of 4 injections per date of service
D9612	Therapeutic parenteral drugs, two or mo re administrations, different medications
D9910	Application of desensitizing medicament: once in 12 months per provider for permanent teeth

D9930	Treatment of complications (post-surgical) - unusual circumstances, by report: once per date of service per provider
D9951	Occlusal adjustment - limited: once in 12 months, age 13+
D9999	Unspecified adjunctive procedure, by report
Major Services	
D2710	Crown - resin-based composite (indirect): once in 5 years, age 13+
D2712	Crown - 3/4 resin-based composite (indirect): once in 5 years, age 13+
D2721	Crown - resin with predominantly base metal: once in 5 years, age 13+
D2740	Crown - porcelain/ceramic substrate: once in 5 years, age 13+
D2751	Crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D2781	Crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D2783	Crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D2791	Crown - full cast predominantly base metal: once in 5 years, age 13+
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament: once per primary tooth
D3221	Pulpal debridement, primary an d permanent teeth: once per tooth
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development: once per permanent tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary toot h (excluding final restoration): once per primary tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration): once per primary tooth
D3310	Endodontic therapy, anterior tooth (exclu ding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3346)
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3347)
D3330	Endodontic therapy, molar (excluding fi nal restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3348)
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - bicuspid
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.): once per permanent tooth
D3352	Apexification/recalcification - interim medication replacement: once per permanent tooth
D3410	Apicoectomy - anterior
D3421	Apicoectomy - bicuspid (first root)
D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling - per root
D3910	Surgical procedure for isol ation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+

D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4265	Biologic materials to aid in soft and osseous tissue regeneration
D4341	Periodontal scaling and root planing - four or more teeth per quadrant: once per quadrant in 24 months; age 13+
D4342	Periodontal scaling and root planing - one to three teeth per quadrant: once per quadrant in 24 months; age 13+
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff): included in fee for completed service (D4210, D4211, D4260, D4261) if same provider. Once per patient to different provider.
D4999	Unspecified periodontal pr ocedure, by report: age 13+
D5110	Complete denture - maxillary: once in 5 years
D5120	Complete denture - mandibular: once in 5 years
D5130	Immediate denture - maxillary: once per patient
D5140	Immediate denture - mandibular: once per patient
D5211	Maxillary partial denture - resin base (i ncluding any conventional clasps, rests and teeth): once in 5 years
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth): once in 5 years
D5213	Maxillary partial denture - cast metal fr amework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5410	Adjust complete denture - maxillary: pe r provider, once per date of service and twice in 12 months
D5411	Adjust complete denture - mandibular: per provider, once per date of service and twice in 12 months
D5421	Adjust partial denture - maxillary: per provider, once per date of service and twice in 12 months
D5422	Adjust partial denture - mandibular: pe r provider, once per date of service and twice in 12 months
D5511	Repair broken complete denture base, mandibular: per provider, once per arch per date of service and twice in 12 months
D5512	Repair broken complete denture base, maxillary: per provider, once per arch per date of service and twice in 12 months

D5520	Replace missing or broken teeth - comp lete denture (each tooth): per provider, 4 per arch per date of service and twice per arch in 12 months
D5611	Repair resin denture base, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5612	Repair resin denture base, maxillaryr: per provider, once per arch per date of service and twice per arch in 12 months
D5621	Repair cast partial framework, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5622	Repair cast partial framework, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5630	Repair or replace broken clasp - per t ooth: per provider, 3 per date of service and twice per arch in 12 months
D5640	Replace broken teeth - per tooth: per provider, 4 per arch per date of service and twice per arch in 12 months
D5650	Add tooth to existing pa rtial denture: per provider, 3 per date of service and once per tooth
D5660	Add clasp to existing partial denture - pe r tooth: per provider, 3 per date of service and twice per arch in 12 months
D5730	Reline complete maxillary dentur e (chairside): once in 12 months
D5731	Reline complete mandibular denture (chairside): once in 12 months
D5740	Reline maxillary partial denture (chairside): once in 12 months
D5741	Reline mandibular partial dentur e (chairside): once in 12 months
D5750	Reline complete maxillary denture (laboratory): once in 12 months
D5751	Reline complete mandibular denture (laboratory): once in 12 months
D5760	Reline maxillary partial denture (laboratory): once in 12 months
D5761	Reline mandibular partial dentur e (laboratory): once in 12 months
D5850	Tissue conditioning, maxillary: tw ice per prosthesis in 36 months
D5851	Tissue conditioning, mandibular: twice per prosthesis in 36 months
D5862	Precision attachment, by report: includ ed in fee for prosthetic and restorative procedure and not separately payable
D5863	Overdenture – complete maxillary: once in 5 years
D5864	Overdenture – partial maxillary: once in 5 years
D5865	Overdenture – complete mandibular: once in 5 years
D5866	Overdenture - partial mandibular: once in 5 years
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement

D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification: twice in 12 months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification: twice in 12 months
D5960	Speech aid prosthesis, modification: twice in 12 months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Second stage implant surgery
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6052	Semi-precision attachment abutment
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown- porcelain fused to high noble alloys
D6067	Implant supported crown- high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for ca st metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD- porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD- high noble alloys
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Provisional implant crown: included in fee for implant services and not separately payable
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown: once in 12 months per provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture: once in 12 months per provider
D6094	Abutment supported crown - titanium and ti tanium alloys
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Implant removal, by report
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant /abutment supported fixed dentur e for partially edentulous arch – maxillary
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6194	Abutment supported retainer crown for FPD- titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6199	Unspecified implant procedure, by report
D6211	Pontic - cast predominantly base metal: once in 5 years, age 13+

D6241	Pontic - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6245	Pontic - porcelain/ceramic: once in 5 years, age 13+
D6251	Pontic - resin with predominantly base metal: once in 5 years, age 13+
D6721	Retainer crown - resin with predominantly base metal: once in 5 years, age 13+
D6740	Retainer crown - porcelain/ceramic: once in 5 years, age 13+
D6751	Retainer crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6781	Retainer crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D6783	Retainer crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D6784	Retainer crown ¾ - titanium and titanium alloys: once in 5 years, age 13+
D6791	Retainer crown - full cast predominantly base metal: once in 5 years, age 13+
D6930	Re-cement or re-bond fixed partial denture: once in 12 months per same provider
D6980	Fixed partial denture repair necessitated by restorative material failure: once in 12 months of initial placement or previous repair by same provider
D6999	Unspecified fixed prosthodontic procedure, by report: once in 12 months of initial placement by same provider
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requ iring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth: once per arch regardless of the number of teeth involved for permanent anterior teeth
D7280	Surgical access of an unerupted tooth
D7283	Placement of device to fac ilitate eruption of impacted tooth
D7285	Incisional biopsy of oral tissue -hard (bon e, tooth): once per arch per date of service
D7286	Incisional biopsy of oral tissue -soft: maximum of 3 per date of service
D7290	Surgical repositioning of teeth: once per arch for permanent teeth for patients in active orthodontic treatment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report: once per arch
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conj unction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization): once per arch in 5 years
D7350	Vestibuloplasty - ridge extension (includi ng soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue): once per arch
D7410	Excision of benign lesion up to 1.25 cm

D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible): once per quadrant
D7472	Removal of torus palatinus: once in the patient's lifetime
D7473	Removal of torus mandibularis: once per quadrant
D7485	Surgical reduction of osseous tuberosity: once per quadrant
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage of abscess - intraoral soft tissue: once per quadrant per same date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces): once per quadrant per same date of service
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue: once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system: once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone: once per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus closed reduction may include stabilization of teeth
D7671	Alveolus, open reduction may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth

D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: discectomy
D7877	Arthroscopy - surgical: debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment: once per date of service per provider, two in 12 months per provider
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	Lefort I (maxilla - total)
D7947	Lefort I (maxilla - segmented)
D7948	Lefort II or lefort III (osteoplasty of fa cial bones for midface hypoplasia or retrusion) - without bone graft
D7949	Lefort II or lefort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure: once per arch per date of service
D7963	Frenuloplasty: once per arch per date of service
D7970	Excision of hyperplastic tissue - per arch: once per arch per date of service
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity: once per quadrant per date of service

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

Schedule of Non-Covered Services

The Procedure Codes and nomenclature in this schedule are copyright of the American Dental Association. This table represents Procedure Codes and nomenclature excerpted from the version of CDT in effect at the date of this printing.

The following Procedure Codes are not Essential Health Benefits; therefore, they are not covered by this Plan.

Procedure Code	Procedure Description and Limitations
Diagnostic	
D0190	Screening of a patient
D0191	Assessment of a patient
D0419	Assessment of salivary flow by measurement
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures

Restorative	
D2542	Onlay - metallic - two surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces
D2642	Onlay - porcelain/ceramic - two surfaces
D2643	Onlay - porcelain/ceramic - three surfaces
D2644	Onlay - porcelain/ceramic - four or more surfaces
D2662	Onlay - resin-based composite - two surfaces
D2663	Onlay - resin-based composite - three surfaces
D2664	Onlay - resin-based composite - four or more surfaces
D2720	Crown - resin with high noble metal
D2722	Crown - resin with noble metal
D2750	Crown - porcelain fused to high noble metal
D2752	Crown - porcelain fused to noble metal
D2753	Crown - porcelain fused to titanium and titanium alloys
D2780	Crown - 3/4 cast high noble metal
D2782	Crown - 3/4 cast noble metal
D2790	Crown - full cast high noble metal
D2792	Crown - full cast noble metal
D2794	Crown - titanium and titanium alloys
Endodontics	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3450	Root amputation - per root
D3920	Hemisection (including any root removal), not including root canal therapy
D3950	Canal preparation and fitting of preformed dowel or post
Periodontics	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft – retained natural tooth – first site in quadrant
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant
D4266	Guided tissue regeneration - resorbable barrier, per site
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)
D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site
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
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
Prosthodontics, removable	
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular

D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5876	Add metal substructure to acrylic full denture (per arch)
Prosthodontics, fixed	
D6205	Pontic - indirect resin based composite
D6210	Pontic - cast high noble metal
D6212	Pontic - cast noble metal
D6214	Pontic - titanium and titanium alloys
D6240	Pontic - porcelain fused to high noble metal
D6242	Pontic - porcelain fused to noble metal
D6243	Pontic - porcelain fused to titanium and titanium alloys
D6250	Pontic - resin with high noble metal
D6252	Pontic - resin with noble metal
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6549	Retainer – for resin bonded fixed prosthesis
D6608	Retainer onlay - porcelain/ceramic, two surfaces
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces
D6610	Retainer onlay - cast high noble metal, two surfaces
D6611	Retainer onlay - cast high noble metal, three or more surfaces
D6612	Retainer onlay - cast predominantly base metal, two surfaces
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces
D6614	Retainer onlay - cast noble metal, two surfaces
D6615	Retainer onlay - cast noble metal, three or more surfaces
D6634	Retainer onlay - titanium
D6710	Retainer crown - indirect resin based composite
D6720	Retainer crown - resin with high noble metal
D6722	Retainer crown - resin with noble metal
D6750	Retainer crown - porcelain fused to high noble metal
D6752	Retainer crown - porcelain fused to noble metal
D6753	Retainer crown - porcelain fused to titanium and titanium alloys
D6782	Retainer crown - 3/4 cast noble metal
D6794	Retainer crown - titanium and titanium alloys
Oral Maxillofacial Prosthetics	
D7287	Exfoliative cytological sample collection
D7288	Brush biopsy - transepithelial sample collection
Adjunctive General Services	
D9450	Case presentation, detailed and extensive treatment planning
D9942	Repair and/or reline of occlusal guard
D9943	Occlusal guard adjustment
D9944	Occlusal guard – hard appliance, full arch
D9945	Occlusal guard – soft appliance, full arch
D9946	Occlusal guard – hard appliance, partial arch
D9995	Teledentistry - synchronous; real-time encounter
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review

Limitations

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

(2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(3) Exam[covered codes only between D0120 – D0180] and cleaning limitations[D1110, D1120]:

a) Delta Dental will pay for periodic oral examinations[D0120] (except after hours exams[D9440] and exams for observation[D9430]) no more than once every six (6) months per provider and routine cleanings[D1110, D1120], including scaling in presence of generalized moderate or severe gingival inflammation[D4346] (including periodontal maintenance[D4910] or any combination thereof) no more than once every six (6) months. Detailed[D0160], limited[D0140] and comprehensive[D0150, D0180] oral examinations are covered once per patient per provider. Re-evaluation – limited, problem focused exams (established patient; not post-operative visits)[D0170] are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12 month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation. See note on additional Benefits during pregnancy.
b) Periodontal maintenance[D4910] is limited to Enrollees age 13 and older once in a calendar quarter and only in the 24 months following the last scaling and root planing. A full mouth debridement[D4355] is included in in the fee for other periodontal procedures and is not payable separately.
c) Note that periodontal maintenance[D4910], Procedure Codes that include periodontal maintenance and full mouth debridement[D4355] are covered as a Basic Benefit, and routine cleanings[D1110, D1120] including scaling in presence of generalized moderate or severe gingival inflammation[D4346] are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance[D4910] is only covered when performed following active periodontal therapy[D4260, D4261, D4341, D4342].
d) Caries risk assessments[D0601, D0601,D0603] are allowed once in 36 months.
e) Interim caries arresting medicament applications[D1354] are covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.

(4) X-ray limitations:

a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series[D0210] when the fees for any combination of intraoral x-rays[D0220 – D0240] in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film[D0330] is submitted with supplemental film(s)[D0220, D0230, D0270-D0274, D0277], Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series[D0210].
c) If a panoramic film[D0330] is taken in conjunction with an intraoral complete series [D0210], Delta Dental considers the panoramic film to be included in the complete series.
d) Intraoral - periapical radiographic images[D0220,D0230] are limited to a maximum of 20 in any 12 month period. Intraoral - occlusal radiographic images[D0240] are limited to two (2) in any six (6) month period.
e) A complete intraoral series[D0210] and panoramic film[D0330] are each limited to once every 36 months per provider. Additional panoramic films may be allowed when documented as essential for a follow-up/post-operative exam (such as after oral surgery).

f) Bitewing x-rays, single radiographic image[D0270] is limited to once per date of service. Bitewing - two or more radiographic images[D0272 – D0277], are limited to once every six (6) months per provider. Bitewing - four radiographic images[D0274] are limited to Enrollees age 10 and older. Bitewings – two or more radiographic images are not billable to the Enrollee or Delta Dental within six (6) months of a full mouth series unless warranted by special circumstances.

(5) Cephalometric x-rays[D0340] and tomographic surveys[D0322] are covered twice (2) in any 12 month period per provider. Diagnostic casts[D0470] are covered only for the evaluation of Orthodontic Services and are provided once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment). See Orthodontic Limitations as age limits may apply. 3D x-rays[D0351] are covered once per date of service.

(6) The fee for pulp vitality tests[D0460] is included in the fees for diagnostic[covered codes only between D0100 – D0999], restorative[covered codes only between D2000 – 2999], endodontic[covered codes only between 3000 – D3999] and emergency procedures[D9110] and is not payable separately.

(7) Topical application of fluoride solutions[D1206,D1208] is limited to once in a six (6) month period.

(8) Space maintainer limitations[D1510 – D1575]:

a) Except for distal shoe space maintainers[D1575], space maintainers[D1510,D1520] are limited to Enrollees through age 17 and covered once per quadrant in a lifetime, except bilateral space maintiners[D1516, D1517, D1526, D1527] which are covered once per arch in a lifetime.
b) Distal shoe space maintainer - fixed – unilateral[D1575] is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
c) Recementation of space maintainer[D1551, D1552, D1553] is limited to once per provider per applicable arch or quadrant.
d) The removal of a fixed space maintainer[D1556, D1557, D1558] is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(9) Sealants[D1351] are limited as follows:

a) once per tooth per provider every 36 months and only to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
b) repair[D1353] or replacement[D1351] of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement by the original provider.

(10) Delta Dental will not cover replacement of an amalgam[D2140 –D2161], prefabricated crown[D2929 – D2934] or resin-based composite restorations (fillings)[D2330 –D2394] within 12 months of treatment for primary teeth or 36 months of treatment for permanent teeth. Replacement restorations within 12 months for primary teeth and within 24 months for permanent teeth are included in the fee for the original restoration.

(11) Protective restorations (sedative fillings)[D2940] are allowed once per tooth per provider in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

(12) Therapeutic pulpotomy[D3220] is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment[D9110] is made when performed on permanent teeth.

(13) Pulpal therapy (resorbable filling)[D3230, D3240] for anterior primary teeth and pulpal debridement for primary and permanent teeth[D3221] are limited to once per tooth per lifetime. Retreatment of root canal therapy[D3346 – D3348] by the same Provider/Provider office within 12 months is considered part of the original procedure.

(14) Apexification[D3351 – D3352] is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth with the fee for the final visit included in the fee for the final root canal.

(15) Retreatment of apical surgery[D3410, D3421,D3425, D3426, D3427, D3430] by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Pin retention[D2951] is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(17) Palliative treatment[D9110] is allowed once per date of service per provider regardless of the number of teeth and/or areas treated, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

(18) Periodontal limitations[covered codes only between D4000 – D4999]:

a) Benefits for periodontal scaling and root planing[D4341, D4342] in the same quadrant are limited to once in every 24-month period for Enrollees age 13 and older.
b) Periodontal surgery[covered codes only between D4210 – D4265] in the same quadrant is limited to once in every 36-month period for Enrollees age 13 and older and includes any surgical re-entry or scaling and root planing[D4341, D4342] performed within 36-months by the same dentist/dental office.
c) Periodontal services, including covered graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions[D7111, D7140,D7210, D7220, D7230, D7240, D7241, D7250], periradicular surgery [covered codes only between D3410-D3430], ridge augmentation[D7340, D7350, D7950-D7952] or implants [covered codes only between D6010-D6050].
d) Periodontal surgery[covered codes only between D4210 – D4265] is subject to a 30 day wait following periodontal scaling and root planing[D4341, D4342] in the same quadrant.
e) Cleanings (regular and periodontal)[D1110, D1120,D4346, D4910] and full mouth debridement D4355 are subject to a 30 day wait following periodontal scaling and root planing[D4341, D4342] if performed by the same Provider office.
f) When implant procedures[covered codes only between D6000 – D6199] are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure[D6081] is covered as a basic benefit and are limited to once in a 24-month period.

(19) Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth[D7270] are covered once per arch regardless of number of teeth invovled for permanent, anterior teeth only.

(20) Surgical repositioning[D7290] of teeth and transseptal fiberotomy/supra crestal fiberotomy [D7291], by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.

(21) Vestibuloplasty - ridge extension (secondary epithelialization)[D7340] is covered once per arch in a five (5) year period. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)[D7350] is covered once per arch in a lifetime.

(22) Removal of lateral exostosis (maxilla or mandible)[D7471] and of torus madibularis[D7473], as well as the surgical reduction of osseous tuberosity[D7485], are limited to once per quadrant per lifetime. Removal of torus palatinus[D7472] is limited to once per lifetime.

(23) Incision and drainage of abscess – intraoral soft tissue[D7510, D7511] is limited to one (1) per quadrant on the same date of service.

(24) Partial ostectomy/sequestrectomy for removal of non-vital bone[D7550] is limited to on (1) per quadrant on the same date of service.

(25) Palatal lift prosthesis modification[D5959] and speech aid prosthesis modification[D5960] are limited to twice in a 12 month period.

(26) Crowns[covered codes D2710 – D2794], excluding prefabricated crowns [covered codes only betweenD2929 – D2934], are limited to Enrollees age 13 and older and are covered not more often than once in a five (5) year period except when Delta Dental determines the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

(27) Post and core services[covered codes only between D2952 - D2957] are covered once per tooth in a lifetime on permanent teeth.

(28) Crown repairs[D2980] are are not a benefit within 12 months of initial crown placement or previous repair for the same provider.

(29) When allowed within six (6) months of a restoration[D2140-D2161, D2330-D2335, D2391-D2394], the Benefit for a Crown, Inlay/Onlay[covered codes only between D2510 – D2794] or fixed prosthodontic service[covered codes only between D6200- D6999] will be reduced by the Benefit paid for the restoration.

(30) Removable Denture Repairs[D5511, D5512, D5611, D5612, D5621, D5622] are covered once per arch per date of service per provider and not more than twice in any twelve (12) month period per provider. Adding teeth to an existing partial denture [D5650] is covered once per tooth and is limited to a maximum of three (3) per date of service per provider.

(31) Implant services[covered codes only between D6000 – D6199] are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Delta Dental for medical necessity for prior authorization. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Exceptional medical conditions include, but are not limited to:

a) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
b) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
c) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
d) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

(32) Fixed partial dentures (bridgework)[D6200 – D6999] are not generally covered but shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture[covered codes only between D5211 – D5283]. The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60 month period and only for Enrollees age 13 and older.

Medical conditions, which preclude the use of a removable partial denture, include:

a) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
b) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
c) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

(33) Prosthodontics[D5110, D5120, D5211 – D5224, D5863 – D5866] covered codes only between D6211 – D6791] that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Immediate dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance[D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791] and/or implant supported prosthesis[D6058-D6077, D6094, D6110-D6117] not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.

(34) When a posterior fixed bridge[covered codes only between D6205 – D6794] and a removable partial denture[D5211 – D5283] are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(35) Recementation of Crowns, Inlays/Onlays or bridges[D2910, D2915, D2920, D6930] is included in the fee for the Crown, Inlay/Onlay or bridge[covered codes only between D2510 – D2794, D6205 – D6974] when performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12 month period by the same Provider/Provider office.

(36) The initial installation of a prosthodontic appliance[covered codes only between D5000 – D5899, D6100 – D6999] and/or implants[covered codes only between D6000 D6199] and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.

(37) TMJ dysfunction procedures are limited to differential diagnosis[covered codes only between D0310-D0322] and symptomatic care[covered codes only between D7810-D7899]. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia[D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791], orthodontia[covered codes only between D8000 – D8999] and full or partial occlusal rehabilitation.

(38) Occlusion analysis – mounted case[D9950], and occlusal adjustments, limited[D9951] and complete[D9952], are limited to one (1) in 12 months for diagnosed TMJ disfunction for permanent dentition and only for Enrollees age 13 and older.

(39) Application of desensitizing medicament[D9951] is limited to once in a 12 month period for permanent teeth only.

(40) Delta Dental limits payment for dentures[covered codes only between D5000 – D5899] to a standard partial[covered codes only between D5211 – D5283] or complete denture[D5110 – D5140] (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments[D5410 – D5422] for the first six (6) months after placement and relines[D5730 – D5761] for the first 12 months after placement.

a) Dentures, removable partial dentures[D5211 – D5283] and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment,

adjustments are limited to twice in a 12 month period per provider and relining is limited to once in a 12 month period.

b) Tissue conditioning[D5850, D5851] is limited to two (2) per prosthesis in a 36 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.

c) Recementation of fixed partial dentures[D6930] is not a benefit within 12 months of a previous re-cementation by the same provider.

(41) Limitations on Orthodontic Services[covered codes only between D8000 – D8999]:

a) Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.

b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

c) The automatic qualifying conditions are:
   i) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   ii) Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   iii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
   iv) A crossbite of individual anterior teeth causing destruction of soft tissue,
   v) An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
   vi) Severe traumatic deviation.

d) The following documentation must be submitted with the request for prior authorization of services by the Provider:
   i) ADA 2006 or newer Claim Form with service code(s) requested;
   ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   iii) Cephalometric radiographic image or panoramic radiographic image;
   iv) HLD score sheet completed and signed by the Orthodontist; and
   v) Treatment plan.

e) The allowances for comprehensive orthodontic treatment procedures (D8080) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention) D8680]. No additional charge to the Enrollee is permitted.

f) Comprehensive orthodontic treatment[D8080] includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

g) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.

h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

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

j) Pre-orthodontic treatment vists[D8660] are allowed once every three (3) months up to a maximum of six (6) per Enrollee.

k) Removable and fixed appliance therapy[D8210,D8220] are allowed once per Enrollee age six (6) to 12.

l) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, Delta Dental will make an allowance for the cost of a standard orthodontic treatment.The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.

m) Repair of an orthodontic appliance[D8696, D8697] inserted under this dental plan is covered once per appliance. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch.
n) Replacement of a lost or broken retainer[D8703, D8704] is a benefit once per arch and only within 24 months following date of service of orthodontic retention.
o) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
p) The removal of fixed orthodontics appliances[D8695] for reasons other than completion of treatment is not a covered benefit.

Exclusions

Delta Dental does not pay Benefits for:

(1) services that are not Essential Health Benefits except as required by state or federal law.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws, services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons[D9972-D9975, D2960-D2962], [exclude covered codes in this list if done for purely cosmetic reasons: D2710 – D2751, D2940, D2330 – D2394, D8000-D8999].

(4) provisional and/or temporary restorations[D2799]. Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth[D7272], treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: periodontal splinting[D4320, D4321] or fixed bridge procedures[D6252 – D6720].

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) pain killers or experimental/investigational procedures.

(9) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia[D9215] and regional/or trigeminal bloc anesthesia[D9211/D9212] are not separately payable procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues)[D4263, D4264].

(11) laboratory processed crowns for Enrollees under age 13[D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791].

(12) interim implants[D6012, D6051, D6118, D6119] and endodontic endosseous implants [D3460].

(13) indirectly fabricated resin-based Inlays/Onlays[D2650 - D2664].

(14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(16) charges incurred for oral hygiene instruction[D1330], a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling[D1320] or broken appointments[D9986] are not separately payable procedures.

(17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(20) Deductibles and/or any service not covered under the dental plan.

(21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(22) the initial placement of any prosthodontic appliance[D5000 – D5899, D6200 – D6999] or implant[D6000 – D6199], unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Delta Dental.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained[D8000-D8999].

(24) missed[D9986] and/or cancelled[D9987] appointments.

(25) action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(26) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(27) dental case management motivational interviewing and patient education to improve oral health literacy.

(28) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(29) diabetes testing.

(30) corticotomy (specialized oral surgery procedures associated with orthodontics)[D7296, D7297].

(31) teledentistry fees are inclusive with office operations and are not a separately payable service.

Information Concerning Benefits for Delta Dental PPO™
Children's Dental PPO for Small Businesses

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

	Delta Dental PPO Providers[2]	Delta Dental Premier® and Non-Delta Dental Providers[2]
(A) Deductibles[1]		
per Enrollee	$75 each Contract Year	$75 each Contract Year
per Family	$150 each Contract Year	$150 each Contract Year
(B) Lifetime Maximums	None	None
(C) Annual Out-of-Pocket Maximum*		
Pediatric Enrollee	$350 each Contract Year	None
Multiple Pediatric Enrollees	$750 each Contract Year	None
(D) Professional Services	**Contract Benefit Levels**	
Dental Service Category:		
Delta Dental will pay or otherwise discharge the Contract Benefit Levels according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	90%
Basic Services	80%	70%
Major Services	50%	50%
Medically Necessary Orthodontic Services	50%	50%
(E) Outpatient Services	Not Covered	
(F) Hospitalization Services	Not Covered	
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.	
(H) Ambulance Services	Not Covered	
(I) Prescription Drug Coverage	Not Covered	
(J) Durable Medical Equipment	Not Covered	
(K) Mental Health Services	Not Covered	
(L) Chemical Dependency Services	Not Covered	
(M) Home Health Services	Not Covered	
(N) Other	Not Covered	

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

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

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

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