DeltaCare® USA

# Dental Health Care Plan

## *Combined Evidence of Coverage and Disclosure Form*

## CA10B

*Underwritten by:*
Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

*Administered by:*
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

# Evidence of Coverage and Disclosure Form

## Introduction

### DeltaCare® USA Dental Health Care Plan

This Combined Evidence of Coverage and Disclosure Form ("EOC") provides information about Your DeltaCare USA Dental Health Care Plan ("Plan") provided by Delta Dental of California ("Company"), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Service Contract with Us.

This document, including the Contract and any attachments, provides the terms and conditions of Your Plan's coverage. Read this document carefully for an explanation of Your coverage, including the *Definitions* section for any terms with special or technical meanings.

**This Combined EOC and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.**

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.

PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

**Terms such as "You," "Your" and "Yourself" means the individuals who are covered. "We," "Us" and "Our" refers to the Company or Our Third Party Administrator ("Administrator").**

**Request Confidential Communications**
You may request to receive communications about Your protected health information from Us at an alternate address or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, contact Us via: email: departmentriskethicsandcompliance@delta.org, or mail:

**Identification Card (ID)**
ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification ("ID") number should be provided to Your Dentist. An ID card may be obtained by visiting Our website at deltadentalins.com.

**Contract**
The Benefit explanations contained in this EOC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the EOC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act ("ERISA").

**Contact Us**
For more information, visit Our website at deltadentalins.com or call Customer Service at 800-422-4234 or You may submit an inquiry to:

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

**Please read the following information so that You will know how to obtain dental services.**

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide 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 Customer Service at 800-422-4234 . To fully understand your coverage, you may wish to carefully review this Dental EOC.

**You must obtain dental Benefits from Your assigned Contract Dentist or be referred for Specialist Services.**

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

| | |
|---|---|
| (A) Deductibles | None |
| (B) Lifetime Maximums | None |
| (C) Professional Services | An Enrollee may be required to pay a Copayment amount for each procedure as shown in the *Description of Benefits and Copayments*, subject to the limitations and exclusions.<br><br>Copayments range by category of service. Examples are as follows:<br>Diagnostic Services — No Cost - $ 5.00<br>Preventive Services — No Cost - $ 45.00<br>Restorative Services — No Cost - $ 195.00<br>Endodontic Services — No Cost - $ 220.00<br>Periodontic Services — No Cost - $ 195.00<br>Prosthodontic Services — No Cost - $ 195.00<br>Oral and Maxillofacial Surgery — No Cost - $ 90.00<br>Orthodontic Services — No Cost - $1900.00<br>Adjunctive General Services — No Cost - $ 125.00<br><br>**NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge.<br><br>Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays are limited to one series of four films in each six month period; replacement of complete dentures, crowns and bridges is limited to once in any five year period. |
| (D) Outpatient Services | Not Covered |
| (E) Hospitalization Services | Not Covered |
| (F) Emergency Dental Coverage | The Enrollee may receive a maximum Benefit of up to $100 per emergency for out-of-area Emergency Services. |
| (G) Ambulance Services | Not Covered |
| (H) Prescription Drug Services | Not Covered |
| (I) Durable Medical Equipment | Not Covered |
| (J) Mental Health Services | Not Covered |
| (K) Chemical Dependency Services | Not Covered |
| (L) Home Health Services | Not Covered |
| (M) Other | Not Covered |

Each individual procedure within each category listed above, and which is covered under the Program has a specific Copayment, which is shown in the *Description of Benefits and Copayments*, in the Combined Evidence of Coverage and Disclosure Form.

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## Definitions

Certain terms used throughout this document begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and how the dental Plan works.

**Authorization:** The process by which We determine if a procedure or treatment is a referable Benefit under Your Plan.

**Benefits:** Dental services provided by Us as described in this EOC, the Contract and Schedules. See also Schedules.

**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).

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

**Contract Dentist:** A Dentist who provides services in general dentistry and who has agreed to provide Benefits under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist Services, except for pediatric dentistry for Dependent Enrollees through age 13, must be obtained from Your Contract Dentist.

**Contract Orthodontist:** A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist except for pediatric dentistry for Dependent Enrollees through age 13 being referred by a pediatric Dentist.

**Contract Specialist:** A Dentist who provides Specialist Services and who has agreed to provide Benefits under this Plan. Except for pediatric dentistry for Dependent Enrollees through age 13, services obtained from a Contract Specialist must be referred by Your Contract Dentist.

**Contract Year:** Period of twelve (12) months starting on the Contract's Effective Date and or the anniversary of the Effective Date and each subsequent 12 month period thereafter.

**Contract Term:** The period during which coverage is in effect whether on a Calendar or Contract Year.

**Contractholder:** The group that enters or executes the Contract to obtain dental coverage.

**Copayment:** The amounts set forth in *Schedule A - Description of Benefits and Copayments* that You are responsible to pay the treating Dentist. Copayments must be paid at the time treatment is received.

**Dependents ("Dependent Enrollees"):** The Primary Enrollee's eligible Dependents and any Individuals eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- The Spouse
- Dependent children from birth to age 26 regardless of marital status
- As otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder.

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

**Effective Date:** The date the Contract or coverage begins.

**Emergency Dental Condition:** Means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, could reasonably 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
- death

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

**Enrollee** ("Primary Enrollee"): Employee or a Dependent ("Dependent Enrollee") enrolled to receive Benefits.

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

**Notice of End of Coverage:** The notice sent to by Us notifying the recipient that Your coverage has been cancelled.

**Notice of Start of Grace Period:** The notice sent by Us that the plan will be terminated unless the premium amount due is received no later than the last day of the Grace Period.

**Open Enrollment Period:** The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

**Optional Treatment:** Any alternative procedure that satisfies the same dental need as a covered procedure and is chosen by You subject to the limitations and exclusions described in the Schedules attached to this EOC.

**Out-of-Network:** Treatment by a Dentist who has not signed a contract with Us to provide Benefits under the terms of this Plan. Also referred to as Non-participating Dentist.

**Plan:** Dental Benefits selected by the Contractholder and provided under the Contract, EOC and any attachments.

**Premium:** Payment made in consideration of dental coverage.

**Schedules:** Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:
- *Schedule A, Description of Benefits and Copayments,* and
- *Schedule B, Limitations and Exclusions of Benefits*

**Special Enrollment Period:** The period outside Your Open Enrollment Period during which individuals eligible as Primary Enrollees or Dependents who experience certain qualifying events may enroll in this Plan.

**Special Health Care Need:** Means a physical or mental impairment, limitation or condition that substantially interferes with Your ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the inability to obtain access to Your Contract Dentist's facility because of a physical disability and 2) the inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

**Specialist Services:** Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be referred by a Contract Dentist. Pediatric Dentist Specialists may refer Dependent Enrollees under their care for Specialist Services as needed.

**Spouse:** An individual who is a partner of the Primary Enrollee as:
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- May be recognized by the Contractholder.

**Treatment in Progress:** means any single dental procedure, as defined by the CDT Code, that has been started while You were eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not You continue to be eligible for Benefits under the DeltaCare USA Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

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

## Eligibility and Enrollment - When Coverage Begins

### Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder.

Eligibility is determined by the Contractholder. We do not make eligibility determinations. We will update Our files to record the eligibility information provided by the Contractholder or its designee.

Your Dependents are eligible to enroll on the same date that You enroll. Later-acquired Dependents become eligible as soon as they acquire dependent status.

Eligibility may be delayed for young children, under the age of 4, until the beginning of any Contract Term immediately following the child's birthday. For coverage to begin on young children, the eligibility notice and additional Premium payment must be received by Us within 30 days of the beginning of the Contract Term immediately following the child's birthday.

Children/students must be dependent upon You for support and maintenance.

There is no coverage under this Plan for Dependents on active military duty.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

**Overage Children**
An overage dependent child may be eligible if:
- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition;
- The child is chiefly dependent on the Primary Enrollee for support; and
- Proof of disability is provided within 60 days of request. Proof of disability will not be required more than one (1) time per year following a two (2) year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition.

**Enrollment Requirements**
If the Contractholder is responsible for Your Premium, coverage will begin on the Contract's Effective Date.

If You are responsible for Your Premium,
- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The eligibility date for such children may be delayed as outlined in the *Eligibility Requirements* section.

You:
- Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
- May not drop coverage and may only make coverage changes during an Open Enrollment Period or Special Enrollment Period because of a qualifying status change.

A Dependent may not be enrolled under more than one Primary Enrollee.

A child who is eligible as a Primary Enrollee and a Dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

**Special Enrollment Periods - Enrollment Changes**
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but not be limited to, the following events:
- Marital status (Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death);
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status);
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125; or
- Any other changes specified by applicable law or regulation.

## How to Use the DeltaCare USA Plan

**Choice of Contract Dentist**
We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You must select a Contract Dentist from the list of Dentists provided at deltadentalins.com. If the Contract Dentist You selected becomes unavailable, We will request You make a selection to another Contract Dentist. If You fail to select a Contract Dentist, the first Contract Dentist You visit will become Your selected Dentist following Your first routine visit.

You may change Your Contract Dentist online or by contacting Customer Service at 800-422-4234. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

We will request You select another Contract Dentist provided Your Contract Dentist:
- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents select another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:
- Partial or full dentures for which final impressions have been taken
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

**Coordination of Care and Referrals**
Services for Benefits must be provided by Your Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist (not including pediatric Dentists), must be referred by Your Contract Dentist.

We have no obligation or liability with respect to services provided by Out-of-Network Dentists, except for Emergency Services or Specialist Services referred by a Contract Dentist and authorized by Us. All authorized Specialist Services claims will be paid less any applicable Copayments.

**Contract Dentist Termination**
If Your Contract Dentist no longer participates in this Plan, the Contract Dentist will complete all treatment in progress as described above.

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the termination of the agreement. For example, the terminating Contract Dentist will complete:
- A partial or full denture for which final impressions have been taken; or

- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If, for any reason, the Contract Dentist is unable to complete treatment, we will make reasonable and appropriate provisions for the completion of such dental treatment by another Contract Dentist.

**Continuity of Care**

Current Enrollees:
You may have the right to the benefit of completion of care with your terminated Dentist for certain acute dental conditions, serious chronic dental conditions and other specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Enrollees:
You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law.

**Special Needs**
If You believe You have a Special Health Care Need, You should contact Our Customer Service department at 800-422-4234.
We will confirm that a Special Health Care Need exists, and what arrangements can be made to assist You in obtaining such Benefits. We will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

**Facility Accessibility**
Many facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Our Customer Service department at 800-422-4234.

**Benefits, Limitations and Exclusions**
This Plan provides Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached Schedules. Only services, supplies or procedures listed in the Schedules and deemed appropriate by Your Contract Dentist are covered under this Plan. Contract Dentists may provide services directly or through associated Dentists, technicians or hygienists who may lawfully perform the services.

**Copayments and Other Charges**
To keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the *Schedules*, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan. Certain procedures require You to pay a Copayment. Copayments are listed in the *Schedules* and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the *Schedules*.

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

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

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

You are responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be Your financial responsibility and will not be paid by this Plan.

**Urgent Dental Services**

Inside the Service Area
An Urgent Dental Service requires prompt dental attention but it is not an Emergency Dental Condition. If You believe that You may need Urgent Dental Services, You can call Your Contract Dentist during normal business hours or after hours.

Out-of-Area Urgent Care
If You need Urgent Dental Services due to an unforeseen dental condition or injury, We cover Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:
- You receive Urgent Dental Services from Out-of-Network Dentist while temporarily outside of the Our Service Area.
- A reasonable person would have believed that Your health would seriously deteriorate if treatment is delayed until returning to Our Service Area.

You do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services You receive from Out-of-Network Dentists are covered if the Benefits would have been covered if You had received the Urgent Dental Services from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after You no longer need Urgent Dental Services. To obtain follow-up care from a Contract Dentist, You can call Your Contract Dentist. You are responsible for any Copayment(s) for Urgent Dental Services received.

**Specialist Services**
Specialist Services for oral surgery, endodontics, orthodontics or periodontics must be referred by Your Contract Dentist.

If You require Specialist Services and there is no Contract Orthodontist or Contract Specialist to provide these services within 35 miles of Your home, the Contract Dentist must receive

Authorization from Us to refer You to an Out-of-Network Orthodontist or Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network orthodontist or Out-of-Network specialist that are not authorized by Us are not covered. We will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

**Second Opinion**
You may request a second opinion if You disagree with, or question, the diagnosis and/or treatment plan determination made by Your Contract Dentist. We may also request that You obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of Your condition. Requests involving cases of an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of Your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Our Customer Service department at 800-422 4234 or write to Us.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Us. We will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. We will only pay for a second opinion which We have approved or authorized. You will be sent a written notification should We decide not to authorize a second opinion. If You disagree with this determination, You may file a grievance with the Plan or with the Department of Managed Health Care. Refer to the *Enrollee Complaint Procedure* section for more information.

**Claims for Reimbursement**
Claims for covered Emergency Services or Specialist Services should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810
Alpharetta, GA 30023

### Provider Compensation

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

In the event We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging You for any sums owed by Us. Except for the provisions in *Emergency Dental Services*, if You have not received Preauthorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services.

**You may obtain further information concerning compensation by calling Us at the toll-free telephone number shown in this booklet.**

### Teledentistry

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

### Processing Policies

The *Schedules* explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists, Contract Orthodontists and Contract Specialists are provided subject to any Copayments. You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

### Coordination of Benefits

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the "primary" plan, We will not reduce Benefits. If this plan is the "secondary" plan, We may reduce Benefits so that the total Benefits paid or provided by all plans do not exceed 100% of total allowable expense.

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 Your total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

**In Order to determine which Plan is primary, We will use the following rules.**

- The plan covering You as an employee or Primary Enrollee is primary over a plan covering You as a dependent.
- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are 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:
    * Secondary to the plan covering You as a dependent; and
    * Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.
- Except as stated in the immediate above paragraph, when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:
    * 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
    * 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.
    * However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.
- In the case of a dependent child of legally separated or divorced parents, the plan covering the child 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 child as a dependent of the parent without legal custody.
- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.

- 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 child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.
- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your 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.
    * First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
    * Second, the Benefits under the continuation coverage.
    * 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 is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

**Enrollee Claims Complaint Procedure**

We will provide notification when any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations, or the quality of dental services performed by a Contract Dentist, You may call Customer Service at 800-422-4234, or a written complaint may be submitted to:

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

Written complaints must include, at a minimum the following information:

- Patient's name

- Primary Enrollee's name, address, telephone number and identification number
- Contractholder's name
- Treating Dentist's name and location

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), You must file a request for review, referred to as a complaint, with Us within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered during the initial benefit determination. The review will be conducted by a person other than the individual who made the original benefit determination, or the individual's subordinate. Upon request and free of charge, You will be provided with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in making the 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 the Plan, We will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be made available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations, the quality management coordinator will provide You an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for a clinical evaluation of the dental services provided. We will make a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition to a patient's dental health, We will provide You and the California Department of Managed Health Care written notification regarding the disposition or pending status of the complaint in a timely fashion or appropriate for the nature of Your condition, not to exceed 3 days.

If You have completed Our grievance process, or You have been involved in Our grievance procedure for more than 30 days, You may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately if You are experiencing an Emergency Dental Condition.

The California 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 800-422-4234 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 Dental Condition, 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 Dental Condition or urgent dental 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 website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

If Your Plan is subject to ERISA, You may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if You have questions about Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The US Department of Labor may be contacted at:

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

If You believe You need further review of Your claim, You may contact Your CA Department of Managed Care.

**Public Policy Participation by Enrollees**
Our Board of Directors includes Enrollees who participate in establishing Our public policy regarding Enrollees through periodic review of Our Quality Assessment program reports and communication from Enrollees. You may submit any suggestions regarding Our public policy in writing to: Customer Service department, P.O. Box 1803, Alpharetta, GA 30023.

**Prepayment Fees/Premiums**
You are required to contribute towards the cost of Your coverage and the cost of Your Dependent's coverage, if applicable.

**Renewal and Termination of Benefits**
This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date that this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

**Cancellation, Rescission or Non-renewal of Coverage**
We may cancel the Contract only:

- upon 30 days' written notice if Contractholder fails to pay premiums in the amount and as required by the Contract;
- upon 60 days' written notice if Contractholder fails to comply with material provisions relating to employer contribution or group participation rates by the Contractholder or employer of the Contract; or
- upon 60 days' written notice if We demonstrate that the Contractholder committed fraud or an intentional misrepresentation of material fact under the terms of the Contract.

**Cancellation of Enrollment due to Non-Payment of Premium**

**Grace Period**
We may cancel the Contract after written notice to the Contractholder if premiums, or a portion of premiums, are not paid by the due date after being billed for the charge. We will provide a Notice of Start of Grace Period 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 is dated. The Contractholder will promptly send or make available a copy of this notice You. Your coverage will continue in effect during day Grace Period.

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

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 reinstated, contact Us at deltadentalins.com." The Contractholder will promptly send or make available a copy of this notice You. If You lose coverage, You may be financially responsible for the payment of claims incurred.

**Cancellation of Enrollment for other than Non-Payment of Premium**
For cancellations, rescission and non-renewals for other than for nonpayment 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 reinstated, contact Us 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 nonpayment of premium submitted prior to the effective date of Your cancellation, renewal or rescission. Please refer to the following *Grievance Regarding Cancellation, Rescission or Nonrenewal* section as well as the *Continuation of Benefits* sections.

**RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL 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 the Department of Managed Health Care ("DMHC").

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal, for reasons other than nonpayment 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.

**Reinstatement of Coverage**
If it is determined the cancellation, rescission or nonrenewal, including a cancellation for nonpayment of premium, is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or nonrenewal. The Contractholder or 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 nonrenewal before reinstatement. Any outstanding premium must be paid prior to reinstatement.

**OPTION 1 - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.**
You may submit online at deltadentalins.com, or

Cancellation - Nonpayment: call 800-765-6003 or write to:

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

Cancellation - Rescission or Nonrenewal: call 866-275-1396 or write to:

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703-8579

You may want to submit Your grievance to Us first if You believe Your cancellation, recession, or nonrenewal 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 Us 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

## General Provisions

**Continuation of Coverage under USERRA**
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any covered Dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- The date You fail 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**
The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website 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).

**Incontestability**
After this Contract has been in force for 3 years from the Effective date, no statement made by the Contractholder will be used to void this Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 3 years or more during Your lifetime.

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

**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, nor will an action be brought at all unless brought within 3 years from expiration of the time within which proof of loss is required by the Contract.

**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.

**Strike, Lay-off and Leave of Absence**
You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 (FMLA) or other applicable state or federal law*.

*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the Premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon their return to active work as if no interruption occurred.

**Important:** FMLA does not apply to all organizations, only those that meet certain size guidelines. Refer to Your Human Resources unit for complete information.

### Organ and Tissue Donation

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

### Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed that waiting times for appointments for care will never be greater than the following time frames:

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

During non-business hours, You will have access to Your Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and who to contact if the You are calling due to an emergency or urgent care situation.

If You contact the Plan's customer service phone number, a Representative will answer the phone within 10 minutes during normal business hours. Should You need interpretation services when scheduling an appointment with any of our Contract Dentist, Contract Orthodontist and Contract Specialist offices, please call 800-422-4234 for assistance.

### Non-Discrimination

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

We:

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

If You need these services, contact Our Customer Service at 800-422-4234.

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

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 800-422-4234
Website Address: deltadentalins.com

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

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

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

# SCHEDULE A

## Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

**Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2026 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.**

| CODE | DESCRIPTION | YOU PAY |
|---|---|---|
| D0100-D0999 | I. DIAGNOSTIC | |
| D0120 | Periodic oral evaluation - established patient ..... | No Cost |
| D0140 | Limited oral evaluation - problem focused ..... | No Cost |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver ..... | No Cost |
| D0150 | Comprehensive oral evaluation - new or established patient ..... | No Cost |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report ..... | No Cost |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) ..... | No Cost |
| D0171 | Re-evaluation - post-operative office visit ..... | $5.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient ..... | No Cost |
| D0190 | Screening of a patient ..... | No Cost |
| D0191 | Assessment of a patient ..... | No Cost |
| D0210 | Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.* ..... | No Cost |

| | | |
|---|---|---|
| D0220 | Intraoral - periapical first radiographic image | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0250 | Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector | No Cost |
| D0251 | Extraoral posterior dental radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |
| D0272 | Bitewings - two radiographic images | No Cost |
| D0273 | Bitewings three radiographic images | No Cost |
| D0274 | Bitewings - four radiographic images - *limited to 1 series every 6 months* | No Cost |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | No Cost |
| D0330 | Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted* | No Cost |
| D0396 | 3D printing of a 3D dental surface scan | No Cost |
| D0415 | Collection of microorganisms for culture and sensitivity | No Cost |
| D0419 | Assessment of salivary flow by measurement - *1 every 12 months* | No Cost |
| D0425 | Caries susceptibility tests | No Cost |
| D0460 | Pulp vitality tests | No Cost |
| D0461 | Testing for cracked tooth | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | No Cost |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | No Cost |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months* | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months* | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months* | No Cost |

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| D0701 | Panoramic radiographic image - image capture only | No Cost |
| D0702 | 2-D cephalometric radiographic image - image capture only | No Cost |
| D0703 | 2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only | No Cost |
| D0705 | Extra-oral posterior dental radiographic image - image capture only | No Cost |
| D0706 | Intraoral - occlusal radiographic image - image capture only | No Cost |
| D0707 | Intraoral - periapical radiographic image - image capture only | No Cost |
| D0708 | Intraoral - bitewing radiographic image - image capture only | No Cost |
| D0709 | Intraoral - comprehensive series of radiographic images - image capture only | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)* | $5.00 |

**D1000-D1999 II. PREVENTIVE**

| | | |
|---|---|---|
| D1110 | Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period* | No Cost |
| D1110 | *Additional prophylaxis cleaning - adult (within the 6 month period)* | $45.00 |
| D1120 | Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period* | No Cost |
| D1120 | *Additional prophylaxis cleaning - child (within the 6 month period)* | $35.00 |
| D1206 | Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1208 | Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1310 | Nutritional counseling for control of dental disease | No Cost |
| D1330 | Oral hygiene instructions | No Cost |
| D1351 | Sealant - per tooth - *limited to permanent molars through age 15* | $5.00 |
| D1353 | Sealant repair - per tooth - *limited to permanent molars through age 15* | $5.00 |
| D1354 | Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period* | No Cost |

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| D1510 | Space maintainer - fixed - unilateral - per quadrant | $10.00 |
| D1516 | Space maintainer - fixed - bilateral, maxillary ..... | $10.00 |
| D1517 | Space maintainer - fixed - bilateral, mandibular ..... | $10.00 |
| D1520 | Space maintainer - removable - unilateral - per quadrant ..... | $10.00 |
| D1526 | Space maintainer - removable - bilateral, maxillary . | $10.00 |
| D1527 | Space maintainer - removable - bilateral, mandibular ..... | $10.00 |
| D1551 | Re-cement or re-bond bilateral space maintainer - maxillary ..... | No Cost |
| D1552 | Re-cement or re-bond bilateral space maintainer - mandibular ..... | No Cost |
| D1553 | Re-cement or re-bond unilateral space maintainer - per quadrant ..... | No Cost |
| D1556 | Removal of fixed unilateral space maintainer - per quadrant ..... | No Cost |
| D1557 | Removal of fixed bilateral space maintainer - maxillary ..... | No Cost |
| D1558 | Removal of fixed bilateral space maintainer - mandibular ..... | No Cost |
| D1575 | Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9* ..... | $10.00 |

**D2000-D2999 III. RESTORATIVE**

*- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
*- When there are more than six crowns in the same treatment plan, You may be charged an additional $100.00 per crown, beyond the 6th unit.*
*- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

| | | |
|---|---|---|
| D2140 | Amalgam - one surface, primary or permanent ..... | No Cost |
| D2150 | Amalgam - two surfaces, primary or permanent .... | No Cost |
| D2160 | Amalgam - three surfaces, primary or permanent .. | No Cost |
| D2161 | Amalgam - four or more surfaces, primary or permanent ..... | No Cost |
| D2330 | Resin-based composite - one surface, anterior ..... | No Cost |
| D2331 | Resin-based composite - two surfaces, anterior ..... | No Cost |
| D2332 | Resin-based composite - three surfaces, anterior ... | No Cost |
| D2335 | Resin-based composite - four or more surfaces (anterior) ..... | No Cost |

| | | |
|---|---|---|
| D2390 | Resin-based composite crown, anterior | No Cost |
| D2391 | Resin-based composite - one surface, posterior | $45.00 |
| D2392 | Resin-based composite - two surfaces, posterior | $55.00 |
| D2393 | Resin-based composite - three surfaces, posterior | $65.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | $75.00 |
| D2510 | Inlay - metallic - one surface | No Cost |
| D2520 | Inlay - metallic - two surfaces | No Cost |
| D2530 | Inlay - metallic - three or more surfaces | No Cost |
| D2542 | Onlay - metallic - two surfaces | No Cost |
| D2543 | Onlay - metallic - three surfaces | No Cost |
| D2544 | Onlay - metallic - four or more surfaces | No Cost |
| D2610 | Inlay - porcelain/ceramic - one surface | $135.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | $150.00 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces | $160.00 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | $150.00 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | $165.00 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces | $175.00 |
| D2650 | Inlay - resin-based composite - one surface | $85.00 |
| D2651 | Inlay - resin-based composite - two surfaces | $95.00 |
| D2652 | Inlay - resin-based composite - three or more surfaces | $115.00 |
| D2662 | Onlay - resin-based composite - two surfaces | $110.00 |
| D2663 | Onlay - resin-based composite - three surfaces | $120.00 |
| D2664 | Onlay - resin-based composite - four or more surfaces | $145.00 |
| D2710 | Crown - resin-based composite (indirect) | $35.00 |
| D2712 | Crown - 3/4 resin-based composite (indirect) | $35.00 |
| D2720 | Crown - resin with high noble metal | $155.00 |
| D2721 | Crown - resin with predominantly base metal | $55.00 |
| D2722 | Crown - resin with noble metal | $95.00 |
| D2740 | Crown - porcelain/ceramic | $195.00 |
| D2750 | Crown - porcelain fused to high noble metal | $195.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | $95.00 |
| D2752 | Crown - porcelain fused to noble metal | $135.00 |

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| D2753 | Crown - porcelain fused to titanium and titanium alloys | $195.00 |
| D2780 | Crown - 3/4 cast high noble metal | $170.00 |
| D2781 | Crown - 3/4 cast predominantly base metal | $70.00 |
| D2782 | Crown - 3/4 cast noble metal | $110.00 |
| D2783 | Crown - 3/4 porcelain/ceramic | $195.00 |
| D2790 | Crown - full cast high noble metal | $170.00 |
| D2791 | Crown - full cast predominantly base metal | $70.00 |
| D2792 | Crown - full cast noble metal | $110.00 |
| D2794 | Crown - titanium and titanium alloys | $195.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | No Cost |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | No Cost |
| D2920 | Re-cement or re-bond crown | No Cost |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp *(anterior)* | No Cost |
| D2928 | Prefabricated porcelain/ceramic crown - permanent tooth | No Cost |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - *anterior* | $10.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | No Cost |
| D2931 | Prefabricated stainless steel crown - permanent tooth | No Cost |
| D2932 | Prefabricated resin crown - *anterior primary tooth* | $15.00 |
| D2933 | Prefabricated stainless steel crown with resin window - *anterior primary tooth* | $10.00 |
| D2940 | Placement of interim direct restoration | No Cost |
| D2949 | Restorative foundation for an indirect restoration | No Cost |
| D2950 | Core buildup, including any pins when required | No Cost |
| D2951 | Pin retention - per tooth, in addition to restoration | No Cost |
| D2952 | Post and core in addition to crown, indirectly fabricated - *includes canal preparation* | No Cost |
| D2953 | Each additional indirectly fabricated post - same tooth - *includes canal preparation* | No Cost |
| D2954 | Prefabricated post and core in addition to crown - *base metal post; includes canal preparation* | No Cost |
| D2956 | Removal of an indirect restoration on a natural tooth | No Cost |

| | | |
|---|---|---|
| D2957 | Each additional prefabricated post - same tooth - *base metal post; includes canal preparation* | No Cost |
| D2971 | Additional procedures to customize a crown to fit under an existing partial denture framework. | $19.00 |
| D2976 | Band stabilization - per tooth - *limited to once in a lifetime per tooth* | No Cost |
| D2980 | Crown repair necessitated by restorative material failure | $10.00 |
| D2981 | Inlay repair necessitated by restorative material failure | $10.00 |
| D2982 | Onlay repair necessitated by restorative material failure | $10.00 |
| D2983 | Veneer repair necessitated by restorative material failure | $10.00 |
| D2989 | Excavation of a tooth resulting in the determination of non-restorability | No Cost |
| D2990 | Resin infiltration of incipient smooth surface lesions - *limited to 1 per 24 months* | $5.00 |

**D3000-D3999 IV. ENDODONTICS**

| | | |
|---|---|---|
| D3110 | Pulp cap - direct (excluding final restoration) | No Cost |
| D3120 | Pulp cap - indirect (excluding final restoration) | No Cost |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | No Cost |
| D3221 | Pulpal debridement, primary and permanent teeth | $5.00 |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | No Cost |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | $5.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | $5.00 |
| D3310 | *Root canal* - endodontic therapy, anterior tooth (excluding final restoration) | $45.00 |
| D3320 | *Root canal* - endodontic therapy, premolar tooth (excluding final restoration) | $90.00 |
| D3330 | *Root canal* - endodontic therapy, molar tooth (excluding final restoration) | $205.00 |
| D3331 | Treatment of root canal obstruction; non-surgical access | $45.00 |

| | | |
|---|---|---|
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | $45.00 |
| D3333 | Internal root repair of perforation defects | $45.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | $60.00 |
| D3347 | Retreatment of previous root canal therapy - premolar | $105.00 |
| D3348 | Retreatment of previous root canal therapy - molar | $220.00 |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | $70.00 |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | $45.00 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.) | $45.00 |
| D3410 | Apicoectomy - anterior | No Cost |
| D3421 | Apicoectomy - premolar (first root) | No Cost |
| D3425 | Apicoectomy - molar (first root) | No Cost |
| D3426 | Apicoectomy (each additional root) | No Cost |
| D3430 | Retrograde filling - per root | No Cost |
| D3450 | Root amputation - per root | No Cost |
| D3471 | Surgical repair of root resorption - anterior | No Cost |
| D3472 | Surgical repair of root resorption - premolar | No Cost |
| D3473 | Surgical repair of root resorption - molar | No Cost |
| D3501 | Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior | No Cost |
| D3502 | Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar | No Cost |
| D3503 | Surgical exposure of root surface without apicoectomy or repair of root resorption - molar | No Cost |
| D3920 | Hemisection (including any root removal), not including root canal therapy | No Cost |
| D3921 | Decoronation or submergence of an erupted tooth | No Cost |

## D4000-D4999 V. PERIODONTICS

*- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $80.00 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $50.00 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | No Cost |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | $80.00 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | $50.00 |
| D4245 | Apically positioned flap | $75.00 |
| D4249 | Clinical crown lengthening - hard tissue | $75.00 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | $175.00 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | $140.00 |
| D4263 | Bone replacement graft - retained natural tooth - first site in quadrant | $195.00 |
| D4264 | Bone replacement graft - retained natural tooth - each additional site in quadrant | $60.00 |
| D4270 | Pedicle soft tissue graft procedure | $195.00 |
| D4274 | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) | $45.00 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft | $195.00 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site | $195.00 |

| | | |
|---|---|---|
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | No Cost |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | No Cost |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period* | No Cost |
| D4355 | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months* | No Cost |
| D4910 | Periodontal maintenance - *limited to 1 treatment each 6 month period* | No Cost |
| D4910 | *Additional periodontal maintenance (within the 6 month period)* | $55.00 |
| D4921 | Gingival irrigation with a medicinal agent - per quadrant | No Cost |

**D5000-D5899 VI. PROSTHODONTICS (removable)**

*- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*

*- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*

*- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

| | | |
|---|---|---|
| D5110 | Complete denture - maxillary | $100.00 |
| D5120 | Complete denture - mandibular | $100.00 |
| D5130 | Immediate denture - maxillary | $120.00 |
| D5140 | Immediate denture - mandibular | $120.00 |
| D5211 | Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | $80.00 |
| D5212 | Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | $80.00 |

| | | |
|---|---|---|
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) | $120.00 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) | $120.00 |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | $80.00 |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | $80.00 |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | $120.00 |
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | $120.00 |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery | $170.00 |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | $170.00 |
| D5227 | Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) | $80.00 |
| D5228 | Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) | $80.00 |
| D5410 | Adjust complete denture - maxillary | No Cost |
| D5411 | Adjust complete denture - mandibular | No Cost |
| D5421 | Adjust partial denture - maxillary | No Cost |
| D5422 | Adjust partial denture - mandibular | No Cost |
| D5511 | Repair broken complete denture base, mandibular | $15.00 |
| D5512 | Repair broken complete denture base, maxillary | $15.00 |
| D5520 | Replace missing or broken teeth - complete denture - per tooth | $5.00 |
| D5611 | Repair resin partial denture base, mandibular | $15.00 |
| D5612 | Repair resin partial denture base, maxillary | $15.00 |
| D5621 | Repair cast partial framework, mandibular | $15.00 |
| D5622 | Repair cast partial framework, maxillary | $15.00 |

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|---|---|---|
| D5630 | Repair or replace broken retentive/clasping materials - per tooth | $15.00 |
| D5640 | Replace missing or broken teeth - partial denture - per tooth | $5.00 |
| D5650 | Add tooth to existing partial denture - per tooth | $5.00 |
| D5660 | Add clasp to existing partial denture - per tooth | $5.00 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | $75.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | $75.00 |
| D5710 | Rebase complete maxillary denture | $35.00 |
| D5711 | Rebase complete mandibular denture | $35.00 |
| D5720 | Rebase maxillary partial denture | $35.00 |
| D5721 | Rebase mandibular partial denture | $35.00 |
| D5725 | Rebase hybrid prosthesis | $35.00 |
| D5730 | Reline complete maxillary denture (chairside) | No Cost |
| D5731 | Reline complete mandibular denture (chairside) | No Cost |
| D5740 | Reline maxillary partial denture (chairside) | No Cost |
| D5741 | Reline mandibular partial denture (chairside) | No Cost |
| D5750 | Reline complete maxillary denture (laboratory) | $35.00 |
| D5751 | Reline complete mandibular denture (laboratory) | $35.00 |
| D5760 | Reline maxillary partial denture (laboratory) | $35.00 |
| D5761 | Reline mandibular partial denture (laboratory) | $35.00 |
| D5765 | Soft liner for complete or partial removable denture - indirect | $35.00 |
| D5820 | Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months* | $45.00 |
| D5821 | Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months* | $45.00 |
| D5850 | Tissue conditioning, maxillary | No Cost |
| D5851 | Tissue conditioning, mandibular | No Cost |

**D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered**

**D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

*- When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional $100.00 per unit, beyond the 6th unit.*
*- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

| | | |
|---|---|---|
| D6210 | Pontic - cast high noble metal | $170.00 |
| D6211 | Pontic - cast predominantly base metal | $70.00 |
| D6212 | Pontic - cast noble metal | $110.00 |
| D6240 | Pontic - porcelain fused to high noble metal | $195.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | $95.00 |
| D6242 | Pontic - porcelain fused to noble metal | $135.00 |
| D6243 | Pontic - porcelain fused to titanium and titanium alloys | $135.00 |
| D6245 | Pontic - porcelain/ceramic | $195.00 |
| D6250 | Pontic - resin with high noble metal | $155.00 |
| D6251 | Pontic - resin with predominantly base metal | $55.00 |
| D6252 | Pontic - resin with noble metal | $95.00 |
| D6600 | Retainer inlay - porcelain/ceramic, two surfaces | $150.00 |
| D6601 | Retainer inlay - porcelain/ceramic, three or more surfaces | $160.00 |
| D6602 | Retainer inlay - cast high noble metal, two surfaces | $100.00 |
| D6603 | Retainer inlay - cast high noble metal, three or more surfaces | $100.00 |
| D6604 | Retainer inlay - cast predominantly base metal, two surfaces | No Cost |
| D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6606 | Retainer inlay - cast noble metal, two surfaces | $40.00 |
| D6607 | Retainer inlay - cast noble metal, three or more surfaces | $40.00 |
| D6608 | Retainer onlay - porcelain/ceramic, two surfaces | $150.00 |

| | | |
|---|---|---|
| D6609 | Retainer onlay - porcelain/ceramic, three or more surfaces | $165.00 |
| D6610 | Retainer onlay - cast high noble metal, two surfaces | $100.00 |
| D6611 | Retainer onlay - cast high noble metal, three or more surfaces | $100.00 |
| D6612 | Retainer onlay - cast predominantly base metal, two surfaces | No Cost |
| D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces | No Cost |
| D6614 | Retainer onlay - cast noble metal, two surfaces | $40.00 |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | $40.00 |
| D6720 | Retainer crown - resin with high noble metal | $155.00 |
| D6721 | Retainer crown - resin with predominantly base metal | $55.00 |
| D6722 | Retainer crown - resin with noble metal | $95.00 |
| D6740 | Retainer crown - porcelain/ceramic | $195.00 |
| D6750 | Retainer crown - porcelain fused to high noble metal | $195.00 |
| D6751 | Retainer crown - porcelain fused to predominantly base metal | $95.00 |
| D6752 | Retainer crown - porcelain fused to noble metal | $135.00 |
| D6753 | Retainer crown - porcelain fused to titanium and titanium alloys | $195.00 |
| D6780 | Retainer crown - 3/4 cast high noble metal | $170.00 |
| D6781 | Retainer crown - 3/4 cast predominantly base metal | $70.00 |
| D6782 | Retainer crown - 3/4 cast noble metal | $110.00 |
| D6783 | Retainer crown - 3/4 porcelain/ceramic | $195.00 |
| D6784 | Retainer crown - 3/4 titanium and titanium alloys | $170.00 |
| D6790 | Retainer crown - full cast high noble metal | $170.00 |
| D6791 | Retainer crown - full cast predominantly base metal | $70.00 |
| D6792 | Retainer crown - full cast noble metal | $110.00 |
| D6930 | Re-cement or re-bond fixed partial denture | No Cost |
| D6940 | Stress breaker | No Cost |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | $10.00 |

## D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

*- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D7111 | Extraction, coronal remnants - primary tooth | No Cost |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | No Cost |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $15.00 |
| D7220 | Removal of impacted tooth - soft tissue | $25.00 |
| D7230 | Removal of impacted tooth - partially bony | $50.00 |
| D7240 | Removal of impacted tooth - completely bony | $70.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | $90.00 |
| D7250 | Removal of residual tooth roots (cutting procedure) | No Cost |
| D7251 | Coronectomy - intentional partial tooth removal, impacted teeth only | $90.00 |
| D7252 | Partial extraction for immediate implant placement - *Once in a lifetime* | $15.00 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | $50.00 |
| D7280 | Exposure of an unerupted tooth | $85.00 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | $85.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | No Cost |
| D7284 | Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures* | No Cost |
| D7286 | Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures* | No Cost |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | No Cost |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | No Cost |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | No Cost |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | No Cost |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | No Cost |

| | | |
|---|---|---|
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm ..... | No Cost |
| D7471 | Removal of lateral exostosis (maxilla or mandible) . | No Cost |
| D7472 | Removal of torus palatinus ..... | No Cost |
| D7473 | Removal of torus mandibularis ..... | No Cost |
| D7509 | Marsupialization of odontogenic cyst ..... | No Cost |
| D7510 | Incision and drainage of abscess - intraoral soft tissue ..... | No Cost |
| D7922 | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site ..... | No Cost |
| D7961 | Buccal/labial frenectomy (frenulectomy) ..... | No Cost |
| D7962 | Lingual frenectomy (frenulectomy) ..... | No Cost |
| D7970 | Excision of hyperplastic tissue - per arch ..... | $50.00 |
| D7971 | Excision of pericoronal gingiva ..... | $50.00 |

**D8000-D8999 XI. ORTHODONTICS**

*- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*

*- The Retention Copayment includes adjustments and/or office visits up to 24 months.*

***Pre and post orthodontic records include:***

| | | |
|---|---|---|
| | *The Benefit for pre-treatment records and diagnostic services includes:* ..... | $200.00 |
| D0210 | Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted* | |
| D0322 | Tomographic survey | |
| D0330 | Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted* | |
| D0340 | 2D cephalometric radiographic image - acquisition, measurement and analysis | |
| D0350 | 2D oral/facial photographic images obtained intra-orally or extra-orally | |
| D0396 | 3D printing of a 3D dental surface scan | |
| D0470 | Diagnostic casts | |

D0801 3D intraoral surface scan - direct

D0802 3D dental surface scan - indirect

D0803 3D facial surface scan - direct

D0804 3D facial surface scan - indirect

*The Benefit for post-treatment records includes:* .... $70.00

D0210 Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition ..... $950.00

D8020 Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19* ..... $950.00

D8030 Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19* ..... $950.00

D8040 Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* ..... $1,150.00

D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* .....$1,700.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* .....$1,700.00

D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* .....$1,900.00

D8091 Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children* .....$2,190.00

D8660 Pre-orthodontic treatment examination to monitor growth and development ..... $25.00

D8680 Orthodontic retention (removal of appliances, construction and placement of *removable* retainers) ..... $275.00

D8681 Removable orthodontic retainer adjustment ..... No Cost

D8999 Unspecified orthodontic procedure, by report - *includes treatment planning session* ..... $100.00

| D9000-D9999 | XII. ADJUNCTIVE GENERAL SERVICES | |
|---|---|---|
| D9110 | Palliative treatment of dental pain - per visit | $5.00 |
| D9211 | Regional block anesthesia | No Cost |
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | No Cost |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia | No Cost |
| D9222 | Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof | $80.00 |
| D9223 | Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof | $80.00 |
| D9224 | Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof | $80.00 |
| D9225 | Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof | $80.00 |
| D9239 | Administration of moderate sedation intravenous - first 15 minute increment, or any portion thereof | $80.00 |
| D9243 | Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof | $80.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | No Cost |
| D9311 | Consultation with a medical health care professional | No Cost |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | $5.00 |
| D9440 | Office visit - after regularly scheduled hours | $20.00 |
| D9450 | Case presentation, subsequent to detailed and extensive treatment planning | No Cost |
| D9912 | Pre-visit patient screening | No Cost |
| D9932 | Cleaning and inspection of removable complete denture, maxillary | No Cost |
| D9933 | Cleaning and inspection of removable complete denture, mandibular | No Cost |

| | | |
|---|---|---|
| D9934 | Cleaning and inspection of removable partial denture, maxillary | No Cost |
| D9935 | Cleaning and inspection of removable partial denture, mandibular | No Cost |
| D9936 | Cleaning and inspection of occlusal guard - per appliance - *limited to 1 D9944, D9945 or D9946 in 3 years* | $10.00 |
| D9943 | Occlusal guard adjustment | $10.00 |
| D9944 | Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years* | $95.00 |
| D9945 | Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years* | $95.00 |
| D9946 | Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years* | $95.00 |
| D9951 | Occlusal adjustment, limited | $20.00 |
| D9952 | Occlusal adjustment, complete | $40.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment* | $125.00 |
| D9986 | Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00* | $10.00 |
| D9987 | Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00* | $10.00 |
| D9990 | Certified translation or sign-language services - per visit | No Cost |
| D9991 | Dental case management - addressing appointment compliance barriers | No Cost |
| D9992 | Dental case management - care coordination | No Cost |
| D9995 | Teledentistry - synchronous; real-time encounter | No Cost |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review | No Cost |
| D9997 | Dental case management - Patients with special Health Care Needs | No Cost |

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred

by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law.

# SCHEDULE B

## Limitations and Exclusions of Benefits

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Placement of interim direct restoration is included in the fee for all covered Endodontic procedures (D3220-D3950) when done on the same date by the same Dentist/dental office.
5. The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure.
6. Benefits provided by a pediatric Dentist are limited to children through age 13 less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
7. The cost to You for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

8. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
9. Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.
10. Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.
11. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law.
12. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).
13. X-ray Limitations:
    - When the frequencies for the comprehensive radiographic images (D0210) and panoramic radiographic images (D0330) differ, the least restrictive frequency will apply.
    - Panoramic images are not considered part of a comprehensive intraoral series.
    - Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
    - Bitewing x-rays are limited to two images for under age 10.
    - Image capture procedures are not separately billable services.

Exclusions

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   * is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch).
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Procedures that may include:
   * precious metal for removable appliances;
   * metallic or permanent soft bases for complete dentures;
   * porcelain denture teeth;
   * precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or
   * personalization and characterization of complete and partial dentures.
8. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
9. Consultations for non-covered Benefits.

10. Dental services received from any dental facility other than the Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before You are eligible with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard, hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch), and D9946 (Occlusal guard-hard appliance, partial arch).
17. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed Dentist.
19. Services or supplies for sleep apnea.
20. Administration of neuromodulators is not a Benefit of the plan.
21. Administration of dermal fillers is not a Benefit of the plan.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

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Toll Free
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