

Dental Health Care Program for  
Eligible Employees and Dependents

**Combined Evidence of Coverage  
and Disclosure Form**

**CA10A**

*Provided by:*

Delta Dental of California  
17871 Park Plaza Drive, Suite 200  
Cerritos, CA 90703

*Administered by:*

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

deltadentalins.com

# EVIDENCE OF COVERAGE

## DISCLOSURE FORM

DeltaCare® USA Dental HMO Program

This booklet is a Combined Evidence of Coverage and Disclosure Form (“EOC”) for your DeltaCare USA Dental HMO Program (“Program”) provided by Delta Dental of California (“Delta Dental”). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract (“Contract”) issued by Delta Dental.

**THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.**

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED “SPECIAL NEEDS”.

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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

**IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her 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 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

The telephone number where you may obtain information about Benefits is 800-422-4234.

INFORMATION CONCERNING BENEFITS UNDER THE DELTACARE USA PROGRAM

**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	<p>An Enrollee may be required to pay a Copayment amount for each procedure as shown in the <i>Description of Benefits and Copayments</i>, subject to the limitations and exclusions.</p> <p>Copayments range by category of service. Examples are as follows:</p> <table border="0"> <tr> <td>Diagnostic Services</td> <td>No Cost - \$ 5.00</td> </tr> <tr> <td>Preventive Services</td> <td>No Cost - \$ 45.00</td> </tr> <tr> <td>Restorative Services</td> <td>No Cost - \$ 195.00</td> </tr> <tr> <td>Endodontic Services</td> <td>No Cost - \$ 220.00</td> </tr> <tr> <td>Periodontic Services</td> <td>No Cost - \$ 195.00</td> </tr> <tr> <td>Prosthodontic Services</td> <td>No Cost - \$ 195.00</td> </tr> <tr> <td>Oral and Maxillofacial Surgery</td> <td>No Cost - \$ 90.00</td> </tr> <tr> <td>Orthodontic Services</td> <td>No Cost - \$1900.00</td> </tr> <tr> <td>Adjunctive General Services</td> <td>No Cost - \$ 125.00</td> </tr> </table> <p><b>NOTE:</b> 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.</p> <p>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.</p>	Diagnostic Services	No Cost - \$ 5.00	Preventive Services	No Cost - \$ 45.00	Restorative Services	No Cost - \$ 195.00	Endodontic Services	No Cost - \$ 220.00	Periodontic Services	No Cost - \$ 195.00	Prosthodontic Services	No Cost - \$ 195.00	Oral and Maxillofacial Surgery	No Cost - \$ 90.00	Orthodontic Services	No Cost - \$1900.00	Adjunctive General Services	No Cost - \$ 125.00
Diagnostic Services	No Cost - \$ 5.00																		
Preventive Services	No Cost - \$ 45.00																		
Restorative Services	No Cost - \$ 195.00																		
Endodontic Services	No Cost - \$ 220.00																		
Periodontic Services	No Cost - \$ 195.00																		
Prosthodontic Services	No Cost - \$ 195.00																		
Oral and Maxillofacial Surgery	No Cost - \$ 90.00																		
Orthodontic Services	No Cost - \$1900.00																		
Adjunctive General Services	No Cost - \$ 125.00																		
(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.

# Table Of Contents

Definitions.....	1
Eligibility for Benefits.....	3
How to use the DeltaCare USA Program - Choice of Contract Dentist.....	4
Continuity of Care.....	5
Special Needs.....	6
Facility Accessibility.....	6
Benefits, Limitations and Exclusions.....	6
Copayments and Other Charges.....	6
Emergency Dental Services.....	7
Urgent Dental Services.....	7
Specialist Services.....	8
Second Opinion.....	8
Claims for Reimbursement.....	9
Provider Compensation.....	9
Processing Policies.....	10
Coordination of Benefits.....	10
Enrollee Claims Complaint Procedure.....	11
Public Policy Participation by Enrollees.....	13
Prepayment Fees/Premiums.....	13
Renewal and Termination of Benefits.....	13

Cancellation, Rescission or Non-renewal of Coverage..... 13

Cancellation of Enrollment due to Non-Payment of Premium..... 14

Continued Coverage Under USERRA..... 17

Continuation of Coverage Under COBRA..... 17

Organ and Tissue Donation..... 18

Non-Discrimination..... 18

Timely Access to Care..... 19

Description of Benefits and Copayments..... 21

Limitations of Benefits..... 39

Exclusions of Benefits..... 40

## Definitions

As used in this booklet:

**BENEFITS** mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

**BILLED FOR THE CHARGE:** a bill that provides, at a minimum, an accurate itemization of the premium amounts due, the due dates(s), and the period of time covered by the premium(s).

**CONTRACT DENTIST** means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

**CONTRACT ORTHODONTIST** means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

**CONTRACT SPECIALIST** means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

**CONTRACTHOLDER** means the organization (employer or other organization) named herein contracting to obtain Benefits.

**COPAYMENT** means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

**ELIGIBLE DEPENDENT** means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

**ELIGIBLE EMPLOYEE** means any employee or group member who is eligible for Benefits as described in this booklet.

**EMERGENCY DENTAL CONDITION** means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, they 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** means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

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

**NOTICE OF END OF COVERAGE:** the notice sent to by US notifying the recipient that the 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** means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

**OUT-OF-NETWORK** means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

**PREAUTHORIZATION** means the process by which Delta Dental determines if a procedure or treatment is a referable covered Benefit under the Enrollee's Plan.

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

**SPECIALIST SERVICES** mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics

or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

**SPOUSE** means a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as 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 the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues 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** mean medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

**WE, US or OUR** means Delta Dental of California or the Administrator as appropriate.

**YOU, YOURS or YOURSELF** means the individuals who are receiving dental services.

## **Eligibility for Benefits**

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Contractholder.

Eligible Dependents become eligible on:

- 1) the date you are eligible for coverage;



- 2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include, Primary Enrollee's Spouse (unless legally separated or divorced) and children from birth up to age 26.

Children include natural children, stepchildren, adopted children, and foster children. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any Calendar Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the Calendar Year immediately following said child's fourth birthday.

An overage dependent child may be eligible if:

- 1) they are incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition;
- 2) they are chiefly dependent on you for support; and
- 3) proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition.

Dependents in active military service are not eligible. No one may be an Eligible Dependent of more than one Eligible Employee. Medicare eligibility will not affect the eligibility of an Eligible Employee or an Eligible Dependent.

## **How to use the DeltaCare USA Program - Choice of Contract Dentist**

To receive Benefits under the DeltaCare USA Program, You must select a Contract Dentist for both yourself and any Dependent Enrollee from the DeltaCare USA network list of Contract Dentists furnished during the enrollment process. You can also access an online provider directory at [deltadentalins.com](http://deltadentalins.com). Collectively, You and Your Eligible Dependents may select no more than three Contract Dentist facilities. If You fail to select a Contract Dentist

or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign You to a Contract Dentist. You may change Your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that Your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment You will receive a DeltaCare USA membership packet that tells you the effective date of Your Program and the address and telephone number of Your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY DENTAL SERVICES AS PROVIDED IN *EMERGENCY DENTAL SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If Your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete 1) a partial or full denture for which final impressions have been taken, and 2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

## **Continuity of Care**

Current Members:

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 Members:

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 an Enrollee believes they have a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental 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 Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-422-4234.

### **Benefits, Limitations and Exclusions**

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

### **Copayments and Other Charges**

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice

is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

## **Emergency Dental Services**

Emergency Dental Services are used for palliative relief, controlling of dental pain and/or stabilizing the patient's condition. The Enrollee's assigned Contract Dentist's facility maintains a 24 hour emergency dental services system, seven days a week. If the Enrollee is experiencing an Emergency Dental Condition, they 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 the Enrollee's assigned Contract Dentist's facility.

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

## **Urgent Dental Services**

### **Inside the Service Area**

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

### **Out of Area Urgent Care**

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

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

Enrollees do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services an Enrollee receives from Out-of-Network Dentists are covered if the Benefits

would have been covered if the Enrollee had received them from Contract Dentists.

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

## **Specialist Services**

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

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered. Delta Dental will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

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

## **Second Opinion**

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of 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 Delta Dental's Customer Service department at 800-422 4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental 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 Dental Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

## **Provider Compensation**

A Contract Dentist is compensated by Delta Dental 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 Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Enrollee. In no event does Delta Dental 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 an Enrollee for any sums owed by Delta Dental. 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 Delta Dental at the toll-free telephone number shown on the back cover of this booklet.**

## **Processing Policies**

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

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.

## **Coordination of Benefits**

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary will be governed by the rules stated in the Contract.

If this Plan is secondary, it will pay the lesser of:

- 1) the amount that it would have paid in the absence of any other dental benefit coverage, or
- 2) the enrollee's total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this Plan.

An Enrollee must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental will, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these

coordination of benefits provisions, and any such reimbursement paid will be deemed to be Benefits under the Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

## **Enrollee Claims Complaint Procedure**

Delta Dental will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department  
P.O. Box 6050  
Artesia, CA 90703

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Contractholder and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental for at least 180 days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental will provide you 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 Contract, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.



Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you 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, Delta Dental will provide you and the California Department of Managed Health Care written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's 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 medical services. The Department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's internet website [www.dmhc.ca.gov](http://www.dmhc.ca.gov) has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration

(EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

## **Public Policy Participation by Enrollees**

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service department, P.O. Box 1803, Alpharetta, GA 30023.

## **Prepayment Fees/Premiums**

This Program requires premiums to be paid to Us. If You are required to pay all or any portion of the premiums, You will be advised of the amount prior to enrollment and it will be deducted from Your earnings by payroll deduction or You will be requested to pay it directly. The Contractholder will be responsible for sending all payments of premiums to Us except payments you are requested to pay directly. Should You voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before You can re-enroll.

## **Renewal and Termination of Benefits**

This Program renews on the anniversary of the contract term unless We provide notice of a change in premiums or Benefits and the Contractholder does not accept the change. All Benefits terminate as of the date that this Program is terminated, You cease to be eligible or such Your enrollment is cancelled. We are not obligated to continue to provide Benefits in such event except for completion of single procedures commenced while coverage 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](http://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](http://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 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](http://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  
17871 Park Plaza Drive, Ste. 200  
Cerritos, CA 90703

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](http://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

## **Continued Coverage Under USERRA**

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract 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:

- 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**

*(Applies to groups with 20 or more Enrollees)* . COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

## **Continuation of Coverage Under Cal-COBRA** *(Applies to groups with 2-19 Enrollees)*

Cal-COBRA (the California Continuation Benefits Replacement Act) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health coverage ("Qualified Beneficiary" to continue coverage for a period of time. We agree to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- continuation of coverage is required to be offered under Cal-COBRA;
- Contractholder notifies us, in writing of any employee who has a qualifying event within 30 days of the qualifying event;
- Contractholder notifies us in writing of any Qualified Beneficiaries currently receiving continuation of coverage from a previous plan;
- Contractholder notifies Qualified Beneficiaries currently receiving continuation coverage under another plan, of the Qualified Beneficiary's ability to continue coverage under Delta Dental's

new group benefit plan for the balance of the period the Qualified Beneficiary is eligible for continuation coverage. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later;

- Contractholder notifies the Qualified Beneficiary if of the ability to elect coverage under the Contractholder's new dental plan, if Contractholder terminates Contract and replaces Delta Dental with another dental plan. Said notice shall be provided the later of 30 days prior to termination of Delta Dental's coverage or when the Enrollees are notified;
- Qualified Beneficiary requests the continuation of coverage within the time frame allowed;
- we receive the required premium for the continued coverage; and
- the Contract stays in force.

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

## **Organ and Tissue Donation**

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

## **Non-Discrimination**

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

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Customer Service Center at 800-422-4234.

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

DeltaCare USA  
17871 Park Plaza Drive, Ste. 200  
Cerritos, CA 90703  
Telephone Number: 800-422-4234  
Website Address: [deltadentalins.com](http://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>.

### **Timely Access to Care**

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

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



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

If an Enrollee calls our Plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee 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.

# SCHEDULE A

## Description of Benefits and Copayments

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

**Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2021 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.**

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
<b>D0100-D0999</b>	<b>I. DIAGNOSTIC</b>	
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 - complete series of radiographic images - <i>limited to 1 series every 24 months</i> .....	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 - <i>limited to 1 series every 6 months</i> .....	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images .....	No Cost
D0330	Panoramic radiographic image .....	No Cost
D0415	Collection of microorganisms for culture and sensitivity .....	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i> .....	No Cost
D0425	Caries susceptibility tests .....	No Cost
D0460	Pulp vitality tests .....	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 - <i>1 every 12 months</i> .....	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i> .....	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i> .....	No Cost
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
D0704	3-D photographic image - 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 - complete series of radiographic images - image capture only .....	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> .....	No Cost

**D1000-D1999                      II. PREVENTIVE**

D1110	Prophylaxis <i>cleaning</i> - adult - 1 D1110, D1120 or D4346 per 6 month period .....	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (within the 6 month period) .....	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - 1 D1110, D1120 or D4346 per 6 month period .....	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (within the 6 month period) .....	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i> .....	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i> .....	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions .....	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1354	Interim caries arresting medicament application - per tooth - <i>child to age 19; 1 per 6 month period</i> ....	No Cost

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 - <i>child to age 9</i> .....	\$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, an Enrollee 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 or involving incisal angle (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

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 ( <i>anterior</i> ) .....	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth .....	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i> .....	\$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth .....	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i> .	\$15.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i> .....	\$10.00
D2940	Protective restoration .....	No Cost
D2941	Interim therapeutic restoration - primary dentition .	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 - <i>includes canal preparation</i> .....	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> .....	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i> .....	No Cost

D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i> .....	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework .....	\$19.00
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
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i> .....	\$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 dentinoceamental 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	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) .....	\$45.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) .....	\$90.00
D3330	<i>Root canal</i> - 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

**D4000-D4999            V. PERIODONTICS**

*- Includes preoperative and postoperative 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 .....	\$50.00
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 - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i> .....	No Cost

D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> .....	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i> .....	No Cost
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i> .....	\$55.00
D4921	Gingival irrigation - 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. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

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

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years 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) .....	\$170.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .....	\$170.00
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 (each 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
D5630	Repair or replace broken retentive/clasping materials - per tooth .....	\$15.00
D5640	Replace broken teeth - per tooth .....	\$5.00
D5650	Add tooth to existing partial denture .....	\$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
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
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i> .....	\$45.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i> .....	\$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, an Enrollee 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 - 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 preoperative and postoperative 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 ....	\$90.00
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
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....	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
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 - complete series of radiographic images
D0322	Tomographic survey
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0350	2D oral/facial photographic images obtained intraorally or extraorally
D0351	3D photographic image
D0470	Diagnostic casts



	<i>The benefit for post-treatment records includes: ....</i>	\$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition .....	\$950.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$950.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,150.00
D8050	Interceptive orthodontic treatment of the primary dentition .....	\$950.00
D8060	Interceptive orthodontic treatment of the transitional dentition .....	\$950.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development .....	\$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers) .....	\$275.00
D8681	Removable orthodontic retainer adjustment .....	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> .....	\$100.00

**D9000-D9999                    XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative (emergency) treatment of dental pain - minor procedure .....	\$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	Deep sedation/general anesthesia - first 15 minutes .....	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment .....	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes .....	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment ..	\$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, detailed and extensive treatment planning .....	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
D9943	Occlusal guard adjustment .....	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$95.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$95.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$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 - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i> .....	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i> .....	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i> .....	\$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 assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

## SCHEDULE B

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

### Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$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. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

## Exclusions of Benefits

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:
  - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
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. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. 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.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or 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 the Enrollee's eligibility with the DeltaCare USA Program. 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, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

## Non-Discrimination Disclosure

### Discrimination Is Against the Law

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

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

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

DeltaCare USA  
PO Box 1803 Alpharetta, GA 30023-1803  
1-800-422-4234  
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

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

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

- qualified interpreters
- information written in other languages

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

**Protect your oral health.** Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit [deltadentalins.com](http://deltadentalins.com). You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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



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)

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)

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)

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)

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

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

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

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

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย ได้รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

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

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրաված ձևով: Անվճար օգնություն համար ինդրոնթեք զանգահարել 1-800-422-4234 (TTY` 711): (Armenian)

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

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

צ קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט, עמעצער דא קען איך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין איינער שפראך. פאר אומזיסטע הילף קענט איר אנקלינגען אַט די דאזיקע נומער: 1-800-422-4234 (Yiddish) 711 ס'איז דא א נומער פאר מענטשען, וואס הערן ניט: 711

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóolta'hígíí nihee hóóló. Díí naaltsoos t'áá Diné bizaad k'éhjí ályaago ałdó' nich'í' ádoolnǫ́łgo bíighah. T'áá jíí'k'e shíká i'doolwoł nínízingo kojí' béésh holdílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information,  
call or write:

Toll Free  
800-422-4234

Delta Dental of California  
17871 Park Plaza Drive, Suite 200  
Cerritos, CA 90703