DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

*Combined Evidence of Coverage and Disclosure Form*

GA13A

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

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 Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("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. 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.

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

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

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), or other entity designated by Delta Dental, operating as an Administrator in the state of Georgia. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

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

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

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.

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

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

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 or a period as otherwise requested by the Client and agreed to by Delta Dental.

**Optional** means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

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

**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 by Delta Dental.

**We, Us or Our** means Delta Dental or the Administrator as appropriate.

**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 Client.

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:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children, beyond the limiting age, up to and including age 25 if they continue to be dependent on you for support and maintenance and are a Full-Time Student; or would have been a Full-Time Student if not prevented by illness or injury.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Foster and adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee.
An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

**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 Client 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.

**How to use the DeltaCare USA Plan - Choice of Contract Dentist**
To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. 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 HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE
FROM THE CONTRACT DENTIST'S FACILITY. 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 (a) a partial or full denture for which final impressions have been taken, and (b) 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).

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 either 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 Services
You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services
Specialist Services must be referred by the assigned Contract Dentist and preauthorized by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Description of Benefits and Copayments, and the limitations and exclusions to determine which procedures are covered under this Program.
Claims for Reimbursement
Claims for covered Emergency Services or preauthorized Specialist Services must 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. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in Emergency 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.

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 shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

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

Enrollee Complaint Procedure
Delta Dental shall 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:
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 Client does not accept the
change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment
Subject to the Enrollee Complaint Procedure, or the Optional Continuation of Coverage provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due or within a 31 day grace period, provided, however, that the Enrollee may continue to receive Benefits during the 15 day period and may be reinstated during the term of this Contract upon payment of any unpaid premiums; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;

3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage
The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, at your expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.
DEFINITIONS

The meaning of key terms used in this section is shown below.

**Qualified Beneficiary** means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

**Qualifying Event** means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1. the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;

Event 2. your death;

Event 3. your divorce or legal separation from your spouse;

Event 4. your dependent's loss of dependent status under the plan; and

Event 5. as to your dependents only, your entitlement to Medicare.

**You** or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).
Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the
election of continued coverage, under another group health plan (as an employee
or dependent) which does not contain or apply any exclusion or limitation
with respect to any pre-existing condition of such a person, if that pre-existing
condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of
the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to
the time that the continuation coverage would otherwise terminate, the employer
shall notify a Qualified Beneficiary either 30 days prior to the termination or when
all Enrollees are notified, whichever is later, of the ability to elect continuation of
coverage under the employer's subsequent dental plan, if any. The continuation
coverage will be provided only for the balance of the period that a Qualified
Beneficiary would have remained covered under the Delta Dental plan had such plan
with the former employer not terminated. The employer shall notify the successor
plan in writing of the Qualified Beneficiaries receiving continuation coverage so
they may be notified of how to continue coverage. The continuation coverage will
terminate if a Qualified Beneficiary fails to comply with the requirements pertaining
to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any
subsequent open enrollment period, if the employer has contracted with another
plan to provide coverage to its active employees. The continuation coverage under
the other plan will be provided only for the balance of the period that a Qualified
Beneficiary would have remained under the Delta Dental plan.
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 CDT-2017 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association 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.

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<thead>
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<th>CODE</th>
<th>DESCRIPTION</th>
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<td><strong>I. DIAGNOSTIC</strong></td>
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<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient .....................................</td>
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<td>Limited oral evaluation - problem focused ..........................................</td>
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<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
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<td>Comprehensive oral evaluation - new or established patient ......................</td>
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<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report ............</td>
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<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
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<td>Re-evaluation - post-operative office visit ..........................................</td>
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<td>Comprehensive periodontal evaluation - new or established patient................</td>
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<td>D0190</td>
<td>Screening of a patient ............................................................................</td>
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<tr>
<td>D0191</td>
<td>Assessment of a patient ..........................................................................</td>
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<td>Intraoral - complete series of radiographic images - <em>limited to 1 series every 24 months</em></td>
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<td>Intraoral - periapical first radiographic image ......................................</td>
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<td>Intraoral - periapical each additional radiographic image ........................</td>
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<td>Intraoral - occlusal radiographic image ...............................................</td>
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<td>Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector</td>
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<td>Extraoral posterior dental radiographic image .......................................</td>
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<td>D0270</td>
<td>Bitewing - single radiographic image ....................................................</td>
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<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images .....................................................</td>
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D0273  Bitewings three radiographic images .................................................. No Cost
D0274  Bitewings - four radiographic images - limited to 1 series every 6 months ................................................................. No Cost
D0277  Vertical bitewings - 7 to 8 radiographic images ......................... No Cost
D0330  Panoramic radiographic image .......................................................... No Cost
D0415  Collection of microorganisms for culture and sensitivity ........ 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 - 1 every 3 years ......................................................... No Cost
D0602  Caries risk assessment and documentation, with a finding of moderate risk - 1 every 3 years ......................................................... No Cost
D0603  Caries risk assessment and documentation, with a finding of high risk - 1 every 3 years ................................................................. No Cost
D0999  Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services) ................................. No Cost

D1000-D1999 II. PREVENTIVE

D1110  Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period ................................................................. No Cost
D1110  Additional prophylaxis cleaning - adult (within the 6 month period) .................................................................................. $45.00
D1120  Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period ................................................................. No Cost
D1120  Additional prophylaxis cleaning - child (within the 6 month period) .................................................................................. $35.00
D1206  Topical application of fluoride varnish - child to age 19; 1 D1206 or D1208 per 6 month period ......................................................... No Cost
D1208  Topical application of fluoride - excluding varnish - child to age 19; 1 D1206 or D1208 per 6 month period ......................................................... No Cost
D1310  Nutritional counseling for control of dental disease ................................................................. No Cost
D1330  Oral hygiene instructions ........................................................................ No Cost
D1351  Sealant - per tooth - limited to permanent molars through age 15 . $10.00
D1352  Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to permanent molars through age 15 ........................................................................................ $10.00
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<thead>
<tr>
<th>Code</th>
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<td>D1354</td>
<td>Interim caries arresting medicament application - <em>child to age 19; 1 per 6 month period</em></td>
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<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
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<td>Space maintainer - removable - unilateral</td>
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<td>Space maintainer - removable - bilateral</td>
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<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
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<td>D1555</td>
<td>Removal of fixed space maintainer</td>
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<tr>
<td>D1575</td>
<td>Distal shoe space maintainer - fixed - unilateral - <em>child to age 9</em></td>
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</table>

**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.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
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</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
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<td>Amalgam - three surfaces, primary or permanent</td>
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<td>Amalgam - four or more surfaces, primary or permanent</td>
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<td>Resin-based composite - one surface, anterior</td>
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<td>Resin-based composite - two surfaces, anterior</td>
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<td>Onlay - porcelain/ceramic - four or more surfaces</td>
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<td>Onlay - resin-based composite - three surfaces</td>
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<td>D2721</td>
<td>Crown - resin with predominantly base metal</td>
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<td>Crown - resin with noble metal</td>
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<td>Crown - porcelain/ceramic substrate</td>
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<td>Crown - porcelain fused to high noble metal</td>
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<td>Crown - porcelain fused to predominantly base metal</td>
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<td>Crown - titanium</td>
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<td>Re-cement or re-bond indirectly fabricated or prefabricated post and core</td>
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<td>Re-cement or re-bond crown</td>
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<td>Reattachment of tooth fragment, incisal edge or cusp (anterior).</td>
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<td>Prefabricated porcelain/ceramic crown - primary tooth - anterior</td>
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<td>Prefabricated stainless steel crown - primary tooth</td>
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<td>Prefabricated stainless steel crown - permanent tooth</td>
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<td>Protective restoration</td>
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<td>Interim therapeutic restoration - primary dentition</td>
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<td>Restorative foundation for an indirect restoration</td>
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<td>Core buildup, including any pins when required</td>
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<tr>
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<td>Pin retention - per tooth, in addition to restoration</td>
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D2952  Post and core in addition to crown, indirectly fabricated - includes canal preparation ................................................................. $95.00
D2953  Each additional indirectly fabricated post - same tooth - includes canal preparation ................................................................. $70.00
D2954  Prefabricated post and core in addition to crown - base metal post; includes canal preparation ......................................................... $80.00
D2957  Each additional prefabricated post - same tooth - base metal post; includes canal preparation ......................................................... $60.00
D2971  Additional procedures to construct new crown under existing partial denture framework ................................................................. $50.00
D2980  Crown repair necessitated by restorative material failure .......... $20.00
D2981  Inlay repair necessitated by restorative material failure .......... $20.00
D2982  Onlay repair necessitated by restorative material failure .......... $20.00
D2983  Veneer repair necessitated by restorative material failure .......... $20.00
D2990  Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15 ......................................................... $10.00

D3000-D3999  IV. ENDODONTICS

D3110  Pulp cap - direct (excluding final restoration) ......................... No Cost
D3120  Pulp cap - indirect (excluding final restoration) ......................... No Cost
D3220  Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament ................................................................. $25.00
D3221  Pulpal debridement, primary and permanent teeth .................. $30.00
D3222  Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development ......................................................... $25.00
D3230  Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) ................................................................. $40.00
D3240  Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) ................................................................. $40.00
D3310  Root canal - endodontic therapy, anterior tooth (excluding final restoration) ................................................................. $95.00
D3320  Root canal - endodontic therapy, bicuspid tooth (excluding final restoration) ................................................................. $185.00
D3330  Root canal - endodontic therapy, molar (excluding final restoration) ................................................................. $335.00
D3331  Treatment of root canal obstruction; non-surgical access .......... $70.00
D3332  Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth ................................................................. $70.00
D3333  Internal root repair of perforation defects ............................... $70.00
D3346  Retreatment of previous root canal therapy - anterior ............... $125.00
D3347  Retreatment of previous root canal therapy - bicuspid ............... $215.00
D3348  Retreatment of previous root canal therapy - molar ............... $365.00
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 .................................................. $115.00
D3421 Apicoectomy - bicuspid (first root) ................................... $125.00
D3425 Apicoectomy - molar (first root) ..................................... $135.00
D3426 Apicoectomy (each additional root) ................................ $80.00
D3427 Periradicular surgery without apicoectomy .................... $115.00
D3430 Retrograde filling - per root ........................................... $60.00
D3450 Root amputation - per root .......................................... $70.00
D3920 Hemisection (including any root removal), not including root canal therapy .......................................................... $60.00

**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 .......................................................... $130.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant .......................................................... $80.00
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth .......................................................... $80.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .......................................................... $135.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .......................................................... $80.00
D4245 Apically positioned flap .................................................. $135.00
D4249 Clinical crown lengthening - hard tissue ......................... $125.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .......................................................... $300.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant .......................................................... $240.00
D4263 Bone replacement graft - retained natural tooth - first site in quadrant .......................................................... $215.00
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant .......................................................... $65.00
D4270 Pedicle soft tissue graft procedure .................................... $215.00
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) .......................................................... $70.00
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft .................................................................................................................. $215.00

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 ......................................................... $215.00

D4341 Periodontal scaling and root planing - four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months .......................................................................................................... $50.00

D4342 Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months .......................................................................................................... $40.00

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 D1110, D1120 or D4346 per 6 month period .................................................................................................................. No Cost

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months ............................................................... $50.00

D4910 Periodontal maintenance - limited to 1 treatment each 6 month period ................................................................................................................................. $35.00

D4910 Additional periodontal maintenance (within the 6 month period) ................................................................................................................................. $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 ................................................................. $285.00

D5120 Complete denture - mandibular ............................................................. $285.00

D5130 Immediate denture - maxillary ............................................................... $305.00

D5140 Immediate denture - mandibular ........................................................... $305.00

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ................................................................................................................................. $245.00

D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ................................................................................................................................. $245.00

D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .................................................................................. $315.00

D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .................................................................................. $315.00
D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ........................................ $245.00
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ........................................ $245.00
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ............................................................................ $315.00
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ............................................................................ $315.00
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth) ............................................................................ $365.00
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth) ............................................................................ $365.00
D5410 Adjust complete denture - maxillary .................................................. $10.00
D5411 Adjust complete denture - mandibular .................................................. $10.00
D5421 Adjust partial denture - maxillary .................................................. $10.00
D5422 Adjust partial denture - mandibular .................................................. $10.00
D5510 Repair broken complete denture base .................................................. $40.00
D5520 Replace missing or broken teeth - complete denture (each tooth) . $20.00
D5610 Repair resin denture base .................................................. $40.00
D5620 Repair cast framework .................................................. $40.00
D5630 Repair or replace broken clasp - per tooth .................................................. $40.00
D5640 Replace broken teeth - per tooth .................................................. $30.00
D5650 Add tooth to existing partial denture .................................................. $30.00
D5660 Add clasp to existing partial denture - per tooth .................................................. $40.00
D5670 Replace all teeth and acrylic on cast metal framework (maxillary) $165.00
D5671 Replace all teeth and acrylic on cast metal framework (mandibular) .................................................. $165.00
D5710 Rebase complete maxillary denture .................................................. $95.00
D5711 Rebase complete mandibular denture .................................................. $95.00
D5720 Rebase maxillary partial denture .................................................. $95.00
D5721 Rebase mandibular partial denture .................................................. $95.00
D5730 Reline complete maxillary denture (chairside) .................................................. $50.00
D5731 Reline complete mandibular denture (chairside) .................................................. $50.00
D5740 Reline maxillary partial denture (chairside) .................................................. $50.00
D5741 Reline mandibular partial denture (chairside) .................................................. $50.00
D5750 Reline complete maxillary denture (laboratory) .................................................. $85.00
D5751 Reline complete mandibular denture (laboratory) .................................................. $85.00
D5760 Reline maxillary partial denture (laboratory) .................................................. $85.00
D5761 Reline mandibular partial denture (laboratory) .................................................. $85.00
D5820 Interim partial denture (maxillary) - limited to 1 in any 12 consecutive months .................................................. $105.00
<table>
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<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
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<td>Tissue conditioning, mandibular</td>
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**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.*

<table>
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<td>D6211</td>
<td>Pontic - cast predominantly base metal</td>
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<td>D6212</td>
<td>Pontic - cast noble metal</td>
<td>$295.00</td>
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<td>Pontic - porcelain fused to high noble metal</td>
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<td>Pontic - resin with high noble metal</td>
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<td>D6251</td>
<td>Pontic - resin with predominantly base metal</td>
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<tr>
<td>D6252</td>
<td>Pontic - resin with noble metal</td>
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<td>Retainer inlay - porcelain/ceramic, two surfaces</td>
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<td>Retainer inlay - cast predominantly base metal, two surfaces</td>
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<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
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<tr>
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<td>Retainer onlay - cast predominantly base metal, two surfaces</td>
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<td>Retainer onlay - cast predominantly base metal, three or more surfaces</td>
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<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
<td>$295.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown - resin with predominantly base metal</td>
<td>$195.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Price</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>D6722</td>
<td>Retainer crown - resin with noble metal</td>
<td>$235.00</td>
</tr>
<tr>
<td>D6740</td>
<td>Retainer crown - porcelain/ceramic</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown - porcelain fused to high noble metal</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer crown - porcelain fused to predominantly base metal</td>
<td>$255.00</td>
</tr>
<tr>
<td>D6752</td>
<td>Retainer crown - porcelain fused to noble metal</td>
<td>$295.00</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - ¾ cast high noble metal</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer crown - ¾ cast predominantly base metal</td>
<td>$255.00</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - ¾ cast noble metal</td>
<td>$295.00</td>
</tr>
<tr>
<td>D6783</td>
<td>Retainer crown - ¾ porcelain/ceramic</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown - full cast predominantly base metal</td>
<td>$255.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown - full cast noble metal</td>
<td>$295.00</td>
</tr>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>$15.00</td>
</tr>
<tr>
<td>D6940</td>
<td>Stress breaker</td>
<td>$25.00</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair necessitated by restorative material failure</td>
<td>$55.00</td>
</tr>
</tbody>
</table>

**D7000-D7999  X. ORAL AND MAXILLOFACIAL SURGERY**

*Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>$5.00</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>$45.00</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>$55.00</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>$75.00</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>$95.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>$115.00</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
<td>$35.00</td>
</tr>
<tr>
<td>D7251</td>
<td>Coronectomy - intentional partial tooth removal</td>
<td>$115.00</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>$110.00</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
<td>$85.00</td>
</tr>
<tr>
<td>D7282</td>
<td>Mobilization of erupted or malpositioned tooth to aid eruption</td>
<td>$85.00</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue - soft - <em>does not include pathology laboratory procedures</em></td>
<td>No Cost</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
<td>$50.00</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
<td>$50.00</td>
</tr>
</tbody>
</table>
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

The benefit for post-treatment records includes: ................. $70.00

D0210 Intraoral - complete series of radiographic images
D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition ...........$1,150.00
D8020 Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19 ........................................ $1,150.00
D8030  Limited orthodontic treatment of the adolescent dentition - 
adolescent to age 19 ............................................... $1,150.00
D8040  Limited orthodontic treatment of the adult dentition - adults, 
including covered dependent adult children ................... $1,350.00
D8050  Interceptive orthodontic treatment of the primary dentition ...... $1,150.00
D8060  Interceptive orthodontic treatment of the transitional dentition ... $1,150.00
D8070  Comprehensive orthodontic treatment of the transitional dentition 
- child or adolescent to age 19 ...................................... $1,900.00
D8080  Comprehensive orthodontic treatment of the adolescent dentition -
adolescent to age 19 .................................................. $1,900.00
D8090  Comprehensive orthodontic treatment of the adult dentition -
adults, including covered dependent adult children .......... $2,100.00
D8660  Pre-orthodontic treatment examination to monitor growth and 
development ............................................................... $25.00
D8680  Orthodontic retention (removal of appliances, construction and 
placement of removable retainers) ..................................... $275.00
D8681  Removable orthodontic retainer adjustment ................................ No Cost
D8999  Unspecified orthodontic procedure, by report - includes treatment 
planning session ......................................................... $100.00

D9000-D9999  XII. ADJUNCTIVE GENERAL SERVICES
D9110  Palliative (emergency) treatment of dental pain - minor procedure $10.00
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 deep sedation or general anesthesia .............. No Cost
D9223  Deep sedation/general anesthesia - each 15 minute increment .. $80.00
D9243  Intravenous moderate (conscious) sedation/analgesia - each 15 
minute increment .......................................................... $80.00
D9310  Consultation - diagnostic service provided by dentist or physician 
other than requesting dentist or physician .......................... $10.00
D9311  Consultation with 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
D9940  Occlusal guard, by report - limited to 1 in 3 years .............. $95.00
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9943</td>
<td>Occlusal guard adjustment</td>
<td>$10.00</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment, limited</td>
<td>$45.00</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment, complete</td>
<td>$95.00</td>
</tr>
<tr>
<td>D9975</td>
<td>External bleaching for home application, per arch; includes materials and</td>
<td>$125.00</td>
</tr>
<tr>
<td></td>
<td>fabrication of custom trays - limited to one bleaching tray and gel for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>two weeks of self-treatment</td>
<td></td>
</tr>
<tr>
<td>D9986</td>
<td>Missed appointment - without 24 hour notice - per 15 minutes of</td>
<td>$10.00</td>
</tr>
<tr>
<td></td>
<td>appointment time</td>
<td></td>
</tr>
<tr>
<td>D9987</td>
<td>Canceled appointment - without 24 hour notice - per 15 minutes of</td>
<td>$10.00</td>
</tr>
<tr>
<td></td>
<td>appointment time</td>
<td></td>
</tr>
<tr>
<td>D9991</td>
<td>Dental case management - addressing appointment compliance barriers</td>
<td>No Cost</td>
</tr>
<tr>
<td>D9992</td>
<td>Dental case management - care coordination</td>
<td>No Cost</td>
</tr>
</tbody>
</table>

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 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 Authorization by Delta Dental, 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. Delta Dental is 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.


10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized 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.

17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023