DeltaCare® USA

Delta Dental Individual & Family

DeltaCare® USA
Family Dental HMO

Combined Policy and Disclosure Form

Provided by:

[Delta Dental of California
100 First Street
San Francisco, California 94105]

Administered by:

[Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, Georgia 30023
800-471-7583]

[deltadentalins.com]
[State website and phone number]

Combined Policy/Disclosure Form ("Policy")

You must make an election on the Exchange for any eligible person you wish to cover under this Policy. If an election is not made on the Exchange for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten by Delta Dental of California ("Delta Dental") and administered by Delta Dental Insurance Company. This Policy discloses the terms and conditions of the individual DeltaCare® USA dental plan available in California. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on your application through the Exchange. It takes effect on the Effective Date shown in the Policy Information attachment included with this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIST SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

A Matrix describing the Plan's major Benefits and coverages can be found at the back of this Policy.

TEN (10)-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied, you may return this Policy within 10 days after you received it. Mail or deliver it to Delta Dental. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Delta Dental, as of its Effective Date, by:

Anthony S. Barth, President & CEO

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POLICY INFORMATION

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-800-471-7583.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-800-471-7583.

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-800-471-7583.

INTRODUCTION

We are pleased to welcome you to this individual DeltaCare USA dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Dentist, but to see him or her on a regular basis.

Eligibility under this Policy is determined by the Exchange. This Policy provides dental Benefits for children and adults as defined in the following sections:

- ***Eligibility Requirement for Pediatric Benefits*** **(Essential Health Benefits)**
- ***Eligibility Requirement for Adult Benefits***

Using This Policy

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

This Policy discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that “you” and “your” mean the Enrollees who are covered under this Policy. “We,” “us” and “our” always refer to Delta Dental or the Administrator]. Persons with Special Health Care Needs should read the section entitled “Special Needs.”

Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at deltadentalins.com or call our Customer Service Center at 800-471-7583.

If you prefer to write to us with your question(s), please mail your inquiry to the following address:

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

Identification Number

Please provide the Enrollee’s identification (“ID”) number to your Dentist whenever you receive dental services. ID cards are not required. If you wish to have an ID card, you may obtain one by visiting our website at deltadentalins.com.

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.

DEFINITIONS

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

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the state of California. Certain functions described throughout this Policy 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 800-471-7583.

Adult Benefits: dental services under this Policy for people age 19 years and older.

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

Benefits: covered dental services provided under the terms of this Policy.

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

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

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

Effective Date: the original date the plan starts.

Eligible Dependent: a person who is a dependent of an Eligible Primary and considered to be a Qualified Individual by the Exchange. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Pediatric Individual: a person who is considered to be a Qualified Individual by the Exchange. Eligible Pediatric Individuals are eligible for Pediatric Benefits as described in this Policy.

Eligible Primary: a person who is considered to be a Qualified Individual by the Exchange. Eligible Primaries are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Emergency Services: care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: 1) placing the Enrollee's dental health in serious jeopardy or 2) serious impairment to dental functions.

Enrollee: an Eligible Primary ("Primary Enrollee"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Individual ("Pediatric Enrollee") enrolled under this Policy to receive Benefits; persons eligible and enrolled under this Policy for Adult Benefits may also be referred to as "Adult Enrollees."

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

Exchange: the California Exchange also referred to as "Covered California."

Open Enrollment Period: the period of the year that the Exchange has established when the Primary Enrollee may change coverage selections for the next Policy Year.

Optional: 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 this Policy.

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

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

Policy: this agreement between Delta Dental and the Primary Enrollee including any application supplied by the Exchange and any Attachments. This Policy constitutes the entire agreement between the parties.

Policy Year: the 12 months starting on January 1st and each subsequent 12 month period thereafter. Policy Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or other exceptional circumstance as determined by the Exchange.

Policyholder: the Primary Enrollee who enrolls for coverage. If this Policy is offered as a child-only or multi-child only Policy by the Exchange, a Primary Enrollee can be an Eligible Pediatric Individual enrolled for coverage by a responsible party, who assumes all responsibilities as a Policyholder. Responsible parties may include: parent, step-parent, adoptive parent, foster parent or Spouse of the Eligible Pediatric Individual.

Premium: the amount payable as provided in the Policy Information attachment included with this Policy.

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

Qualified Individual: an individual determined by the Exchange to be eligible to enroll through the Exchange.

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);

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

Reasonable: an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one (1) attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one (1) attempt to contact Delta Dental for assistance before seeking care from another Dentist.

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

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability or 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: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Spouse: 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 Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides.

Treatment in Progress: 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.

Waiting Period: the amount of time an Enrollee must be enrolled under this Policy for specific services to be covered.

ELIGIBILITY AND ENROLLMENT

The Exchange is responsible for establishing eligibility and reporting enrollment to us. We process enrollment as reported by the Exchange.

This Policy includes Pediatric Benefits and Adult Benefits. Enrollees are eligible for either Pediatric or Adult Benefits according to the requirements listed below:

Eligibility Requirement for Pediatric Benefits

Pediatric Enrollees are Qualified Individuals as determined by the Exchange who are eligible and have enrolled for Pediatric Benefits under this Policy. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor to age 19; and/or
- a Primary Enrollee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

Eligibility Requirement for Adult Benefits

Primary Enrollees and Dependent Enrollees are Qualified Individuals as determined by the Exchange who are eligible and have enrolled for Adult Benefits under this Policy. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee age 19 years of age or older; and/or
- a Primary Enrollee's Spouse age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

A dependent child 26 years of age or older may continue eligibility for Adult Benefits if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- he or she is chiefly dependent on the Primary Enrollee or Spouse for support; and
- 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 the Primary Enrollee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Renewal

This Policy remains in effect for the Policy Year, provided it is not terminated by us or by the Primary Enrollee. The Primary Enrollee will receive renewal information from the Exchange prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the Exchange during the Open Enrollment Period. Provided Delta Dental continues to make this Policy available through the Exchange at the renewal period:

- the Primary Enrollee may elect to choose this Policy, subject to the applicable Premium through the Exchange for this plan at the time of renewal; or
- the Primary Enrollee may not have to make an election through the Exchange in subsequent Open Enrollment Periods to continue coverage. You should refer to the Exchange rules regarding automatic renewal of coverage.

Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Policy by sending Delta Dental or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be at least 14 days from the date of Delta Dental's receipt of the request for termination. If coverage is terminated because the Enrollee is covered by Medicaid, the last day of coverage with Delta Dental is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Delta Dental may terminate coverage due to:

- Enrollee no longer eligible through the Exchange or under the terms of this Policy;
- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- we demonstrate that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under this plan;
- the Primary Enrollee changing to a new policy through the Exchange; or
- Delta Dental ceasing to renew all Policies issued on this form to residents of the state where you live.

If termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility. If you are no longer eligible due to age, termination is effective on the date reported by the Exchange and you should contact the Exchange to see if special enrollment periods apply.

If your coverage is terminated, we will send a written notice to you informing you of the reasons(s) why coverage is terminated and the date that your coverage will end. For Treatment in Progress, we will continue to provide Benefits less any applicable Copayment.

In the event of cancellation of enrollment by Delta Dental, Delta Dental shall return to Policyholder the pro rata portion of the Premiums paid to Delta Dental which corresponds to any unexpired period for which payment had been received, together with any amounts due on

claims, if any, less any amounts owed to Delta Dental. This provision does not apply if the Enrollee engaged in fraud or deception in obtaining Benefits from Delta Dental or knowingly permitted such fraud or deception by another.

An Enrollee who believes that coverage has been, or will be, improperly cancelled, rescinded or not renewed may request a review by the Director of the California Department of Managed Health Care (“Department”) in accordance with Section 1365(b) of the California Health & Safety Code.

Reinstatement

If this Policy is terminated, you may re-enroll in the plan at the next Open Enrollment Period. Any Out-of-Pocket Maximum and/or Waiting Period applicable to your Benefits will start over. However, this Policy may be reinstated prior to Open Enrollment with no break in coverage provided the full Premium due is received by us (see “*Grace Period on Late Payments”)*. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to this Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to this Policy.

Acceptance by Delta Dental of the proper Premiums after termination of this Policy and without requiring a new application, shall reinstate the Contract as though it had never terminated, unless Delta Dental shall, within 20 business days of receipt of such payment, either: 1) refuse the payment so made or 2) issue to Policyholder a new Policy accompanied by written notice stating clearly those respects in which the new Policy differs from this terminated Policy in Benefits, coverage or otherwise.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

The DeltaCare USA plan provides Pediatric and Adult Benefits through a convenient network of Contract Dentists in the state of California. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Policy. Benefits are only available in the state of California. The services are performed as deemed appropriate by your attending Contract Dentist.

Copayments and Other Charges

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

appointments and visits after normal visiting hours are listed in the Schedules attached to this Policy.

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. 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 Services*," if you have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, see "*Emergency Services*" and "*Specialist Services*."

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his/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 800-471-7583. To fully understand your coverage, you may wish to carefully review this EOC.

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

Delta Dental shall provide Contract Dentists at convenient locations during the term of this Policy. Upon enrollment, Delta Dental will assign the Enrollees to one Contract Dentist facility. The Policyholder may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 800-471-7583. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

We will provide you written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; and 3) delivery of crowns when teeth have been prepared.

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

school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

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

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

Emergency Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Services, you should call the Customer Service Center at 800-471-7583 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

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

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the 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.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services should be sent to us within 90 days of *the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not* reasonably possible to submit the claim within that time. 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.

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

Processing Policies

The dental care guidelines for the DeltaCare USA plan 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 plan 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 Center at 800-471-7583 for information regarding the dental care guidelines for DeltaCare USA.

Second Opinions

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 imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service Center at 800-471-7583 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. Refer to the "*Enrollee Complaint Procedure*" section for more information.

Special Needs

If you believe you have a Special Health Care Need, you should contact our Customer Service Center at 800-471-7583. We will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. We will not be responsible for the failure of any Dentist to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Dentist.

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 Center at 800-471-7583.

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 Center at 800-471-7583, or the complaint may be addressed in writing to:

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

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

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

"Complaint" is the same as "grievance."

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

Within five (5) calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist 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 or shall provide a written explanation if additional time is required to report on the complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three (3) 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 Department. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The Department is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone us, your plan, at **1-800-471-7583** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review ("IMR"). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy you receive, if applicable. Premiums are listed in the Policy Information attachment included with this Policy. The Primary Enrollee is responsible for making Premium payments.

Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay your Premium by visiting our website at deltadentalins.com, or by mailing payment to the address below:

Delta Dental Insurance Company
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or due to other extraordinary circumstance as determined by the Exchange.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option by visiting our website at deltadentalins.com or by contacting our Customer Service Center toll-free at 800-471-7583.

Grace Period on Late Payments

For Enrollees receiving an Advanced Premium Tax Credit ("APTC"):

- If your Premium payment is not received by the first of the month, a grace period of three (3) months will be granted. During the grace period, this Policy shall continue in force. However, your coverage for the second and third months of the grace period will be suspended and claims incurred during the second and third months of the grace period will not be paid unless all Premiums due are paid prior to the expiration of the grace period. If Premiums are received during the grace period, then the Enrollees will be reinstated as of the last day of paid coverage. If Premiums are not received prior to the end of the grace period, coverage will be terminated as of the end of the last day of the first month of the grace period.

For Enrollees not receiving an Advanced Premium Tax Credit ("APTC"):

- A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. The grace period will begin after the conclusion of any coverage period for which Delta Dental has received full payment and will extend for 31 days after the conclusion of coverage or for 31 days from the date of notification, whichever is later. This Policy will continue in force during this period if the Premium remains unpaid at the end of the grace period, this Policy may be terminated by Delta Dental in accordance with the notice requirements. In the event this Policy is terminated, Policyholder will owe Delta Dental unpaid Premiums due before this Policy was terminated.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

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

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

Entire Policy; Changes

This Policy, including any application and Attachments, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and

unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Severability

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

Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your Policy.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Conformity with Applicable Laws

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

Third Party Administrator (“TPA”)

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental

providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

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

Impossibility of Performance

Neither party (Policyholder or Delta Dental) shall be liable to the other or be deemed to be in breach of this Policy for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

Non-Discrimination

Delta Dental is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

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

2017 Dental Standard Benefit Plan Design

<table>
<tr><td colspan="2" rowspan="4">Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.
Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.</td><td colspan="2">Family Dental Plan</td></tr>
<tr><td colspan="2">Copay Plan</td></tr>
<tr><td>Pediatric Dental EHB</td><td>Adult Dental</td></tr>
<tr><td>Up to Age 19</td><td>Age 19 and Older</td></tr>
<tr><td colspan="2">Actuarial Value</td><td>83.0%</td><td>Not Calculated</td></tr>
<tr><td colspan="2"></td><td>In-Network</td><td>In-Network</td></tr>
<tr><td colspan="2">Individual Deductible</td><td>None</td><td>None</td></tr>
<tr><td colspan="2">Family Deductible (Two or more children)</td><td>Not applicable</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Individual Out of Pocket Maximum</td><td>$350</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Family Out of Pocket Maximum (Two or More Children)</td><td>$700</td><td>Not Applicable</td></tr>
<tr><td colspan="2">Office Copay</td><td>$0</td><td>$0</td></tr>
<tr><td colspan="2">Waiting Period
(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)</td><td>None</td><td>None</td></tr>
<tr><td colspan="2">Annual Benefit Limit
(the maximum amount the dental plan will pay in the benefit year)</td><td>None</td><td>None</td></tr>
<tr><td>Procedure Category</td><td>Service Type</td><td>Member Cost Share</td><td>Member Cost Share</td></tr>
<tr><td rowspan="6">Diagnostic & Preventive</td><td>Oral Exam</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Preventive - Cleaning</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Preventive - X-ray</td><td>No charge</td><td>No charge</td></tr>
<tr><td>Sealants per Tooth</td><td>No charge</td><td>Not Covered</td></tr>
<tr><td>Topical Fluoride Application</td><td>No charge</td><td>Not Covered</td></tr>
<tr><td>Space Maintainers - Fixed</td><td>No charge</td><td>Not Covered</td></tr>
<tr><td rowspan="4">Basic Services</td><td>Restorative Procedures</td><td rowspan="4">See Benefits shown in Schedule A for 2017 Dental Copay Schedule</td><td rowspan="4">See Benefits shown in Schedule A for 2017 Dental Copay Schedule</td></tr>
<tr><td>Periodontal Maintenance Services</td></tr>
<tr><td>Adult Periodontics (other than maintenance)
(Group Dental Plans only)</td></tr>
<tr><td>Adult Endodontics
(Group Dental Plans only)</td></tr>
<tr><td rowspan="5">Major Services</td><td>Periodontics (other than maintenance)</td><td rowspan="5">See Benefits shown in Schedule A for 2017 Dental Copay Schedule</td><td rowspan="5">See Benefits shown in Schedule A for 2017 Dental Copay Schedule</td></tr>
<tr><td>Endodontics</td></tr>
<tr><td>Crowns and Casts</td></tr>
<tr><td>Prosthodontics</td></tr>
<tr><td>Oral Surgery</td></tr>
<tr><td>Orthodontia</td><td>Medically Necessary Orthodontia</td><td>$350</td><td>Not Covered</td></tr>
</table>

SCHEDULE A
Description of Benefits and Copayments
Delta Dental Individual & Family
DeltaCare® USA
Family Dental HMO

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare® USA plan and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature which is 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.

Out-of-Pocket Maximum (OOPM) for Pediatric Enrollees (Under Age 19)

Pediatric Enrollee…………………………… **$350.00** each Calendar Year

Multiple Pediatric Enrollees……………….. **$700.00** each Calendar Year

OOPM applies only to Essential Health Benefits (EHB) for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Pediatric Benefits under this plan during a Calendar Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments (such as precious or semi-precious metals and material upgrades) or that are not covered under the Policy will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered on the Policy, the financial obligation for Pediatric Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets his or her OOPM, he or she will have no further payment for the remainder of the Calendar Year for Pediatric Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for Pediatric Benefits.

Delta Dental recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact the Customer Service Center at 800-471-7583.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic	No charge	No charge	*Includes office visit, per*	*Includes*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	procedure, by report			*visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	No charge	No charge	*1 per 6 months per Contract Dentist*	
D0140	Limited oral evaluation - problem focused	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	Not covered	*1 per 6 months per Contract Dentist, included with D0120, D0150*	
D0150	Comprehensive oral evaluation - new or established patient	No charge	No charge	*Initial evaluation, 1 per Contract Dentist*	
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	No charge	*6 in 3 months, not to exceed 12 in a 12 month period*	
D0171	Re-evaluation - post-operative office visit	Not covered	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	No charge	*Included with D0150*	
D0190	Screening of a patient	Not covered	No charge		
D0191	Assessment of a patient	Not covered	No charge		
D0210	Intraoral - complete series of radiographic images	No charge	No charge	*1 series every 36 months per Contract Dentist*	*1 series every 24 months*
D0220	Intraoral - periapical first radiographic image	No charge	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*	
D0230	Intraoral - periapical each additional radiographic image	No charge	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*	
D0240	Intraoral - occlusal radiographic image	No charge	No charge	*2 in 6 months per Contract Dentist*	
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	No charge	*1 per date of service*	
D0270	Bitewing - single radiographic image	No charge	No charge	*1 (D0270, D0273) per date of service*	
D0272	Bitewings - two radiographic images	No charge	No charge	*1 (D0272 D0273) in 6 months per Contract Dentist*	
D0273	Bitewings - three radiographic images	No charge	No charge	*1 (D0270, D0273) per date of service; 1 (D0272, D0273) in 6 months per Contract Dentist*	
D0274	Bitewings - four radiographic images	No charge	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*	*1 series every 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*	
D0290	Posterior - anterior or lateral skull and facial bone survey radiographic image	No charge	Not covered	*Limited to trauma or pathology; 3 per date of service*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0310	Sialography	No charge	Not covered		
D0320	Temporomandibular joint arthrogram, including injection	No charge	Not covered	*Limited to trauma or pathology; 3 per date of service*	
D0322	Tomographic survey	No charge	Not covered	*2 in 12 months per Contract Dentist*	
D0330	Panoramic radiographic image	No charge	No charge	*1 in 36 months per Contract Dentist*	*1 every 24 consecutive months*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	Not covered	*2 in 12 months per Contract Dentist*	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	Not covered	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not covered	No charge		
D0460	Pulp vitality tests	No charge	No charge		
D0470	Diagnostic casts	No charge	No charge	*For the evaluation of orthodontic benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).*	
D0502	Other oral pathology procedures, by report	No charge	Not covered	*Performed by an oral pathologist*	
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	Not covered	*1 in 36 months per Contract Dentist or dental office; age 3 and above*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	Not covered	*1 in 36 months per Contract Dentist or dental office; age 3 and above*	
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	Not covered	*1 in 36 months per Contract Dentist or dental office; age 3 and above*	
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	No charge	No charge	*Cleaning; 1 (D1110, D1120) in 6 months*	*Cleaning; 2 per 12 month period*
D1110	Prophylaxis - adult	Not covered	$45		*Up to 2 additional cleanings within the 12 month period*
D1120	Prophylaxis - child	No charge	Not covered	*Cleaning; 1 (D1110, D1120) in 6 months*	
D1206	Topical application of fluoride varnish	No charge	Not covered	*1 (D1206, D1208) in 6 months*	
D1208	Topical application of fluoride - excluding varnish	No charge	Not covered	*1 (D1206, D1208) in 6 months*	
D1310	Nutritional counseling for control of dental disease	No charge	Not covered		
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	Not covered		
D1330	Oral hygiene instructions	No charge	No charge		
D1351	Sealant - per tooth	No charge	Not covered	*1 per tooth in 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*	
D1352	Preventive resin restoration in a moderate to high	No charge	Not covered	*1 per tooth in 36 months per Contract Dentist; limited to*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	caries risk patient - permanent tooth			*permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*	
D1353	Sealant repair - per tooth	No charge	Not covered	*The original dentist or dental office is responsible for any repair or replacement during the 36-month period.*	
D1510	Space maintainer - fixed - unilateral	No charge	Not covered	*1 per quadrant; posterior teeth*	
D1515	Space maintainer - fixed - bilateral	No charge	Not covered	*1 per arch; posterior teeth*	
D1520	Space maintainer - removable - unilateral	No charge	Not covered	*1 per quadrant; posterior teeth*	
D1525	Space maintainer - removable - bilateral	No charge	Not covered	*1 per arch, through age 17; posterior teeth*	
D1550	Re-cement or re-bond space maintainer	No charge	Not covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1555	Removal of fixed space maintainer	No charge	Not covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.					
D2140	Amalgam - one surface, primary or permanent	$25	$25	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2150	Amalgam - two surfaces, primary or permanent	$30	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2160	Amalgam - three surfaces, primary or	$40	$40	*1 in 12 months per Contract Dentist for*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	permanent			*primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2161	Amalgam - four or more surfaces, primary or permanent	$45	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2330	Resin-based composite - one surface, anterior	$30	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2331	Resin-based composite - two surfaces, anterior	$45	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2332	Resin-based composite - three surfaces, anterior	$55	$55	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	$60	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2390	Resin-based composite crown, anterior	$50	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2391	Resin-based composite - one surface, posterior	$30	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2392	Resin-based composite - two surfaces, posterior	$40	$40	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2393	Resin-based composite - three surfaces, posterior	$50	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2394	Resin-based composite - four or more surfaces, posterior	$70	$70	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*	
D2542	Onlay - metallic - two surfaces	Not covered	$185		*1 per 60 months*
D2543	Onlay - metallic - three surfaces	Not covered	$200		*1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not covered	$215		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not covered	$250		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not covered	$275		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not covered	$300		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not covered	$160		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not covered	$180		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not covered	$200		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	$140	$140	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2712	Crown - 3/4 resin-	$190	Not	*1 per 60 months,*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	based composite (indirect)		covered	*permanent teeth; age 13 through 18*	
D2720	Crown - resin with high noble metal	Not covered	$300		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2722	Crown - resin with noble metal	Not covered	$300		*1 per 60 months*
D2740	Crown - porcelain/ceramic substrate	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not covered	$300		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not covered	$300		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not covered	$300		*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not covered	$300		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$310	Not covered	*1 per 60 months, permanent teeth; age 13 through 18*	
D2790	Crown - full cast high noble metal	Not covered	$300		*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2792	Crown - full cast noble metal	Not covered	$300		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	$25	*1 in 12 months per Contract Dentist*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	$25		
D2920	Re-cement or re-bond	$25	$15	*Recementation during*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	crown			*the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not covered	*1 in 12 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$65	Not covered	*1 in 12 months*	
D2931	Prefabricated stainless steel crown - permanent tooth	$75	$75	*1 in 36 months*	
D2932	Prefabricated resin crown	$75	Not covered	*1 in 12 months for primary teeth; 1 in 36 months for permanent teeth*	
D2933	Prefabricated stainless steel crown with resin window	$80	Not covered	*1 in 12 months for primary teeth; 1 in 36 months for permanent teeth*	
D2940	Protective restoration	$25	$20	*1 in 6 months per Contract Dentist*	
D2950	Core buildup, including any pins when required	$20	$20		
D2951	Pin retention - per tooth, in addition to restoration	$25	$20	*1 per tooth regardless of the number of pins placed; permanent teeth*	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	$30	$30	*Performed in conjunction with D2952*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2954	Prefabricated post and core in addition to crown	$90	$60	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Includes canal preparation*
D2955	Post removal	$60	Not covered	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2957	Each additional prefabricated post - same tooth	$35	$35	*Performed in conjunction with D2954*	
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	Not covered	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*	
D2980	Crown repair necessitated by restorative material failure	$50	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*	
D2999	Unspecified restorative procedure, by report	$40	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	$20	$20		
D3120	Pulp cap - indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	$35	*1 per primary tooth*	
D3221	Pulpal debridement, primary and permanent teeth	$40	Not covered	*1 per tooth*	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	Not covered	*1 per permanent tooth*	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	Not covered	*1 per tooth*	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	Not covered	*1 per tooth*	
D3310	Endodontic therapy, anterior tooth (excluding final	$195	$200	*Root canal*	*Root canal*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	restoration)				
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	$235	*Root canal*	*Root canal*
D3330	Endodontic therapy, molar (excluding final restoration)	$300	$300	*Root canal*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$195	$85		
D3333	Internal root repair of perforation defects	$80	Not covered		
D3346	Retreatment of previous root canal therapy - anterior	$240	$245	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3347	Retreatment of previous root canal therapy - bicuspid	$295	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3348	Retreatment of previous root canal therapy - molar	$365	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				a Contract Dentist other than the original treating Contract Dentist/dental office.	
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$85	Not covered	*1 per permanent tooth*	
D3352	Apexification/recalcification - interim medication replacement	$45	Not covered	*1 per permanent tooth*	
D3410	Apicoectomy - anterior	$240	$240	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3421	Apicoectomy - bicuspid (first root)	$250	$250	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3425	Apicoectomy - molar (first root)	$275	$275	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3426	Apicoectomy (each additional root)	$110	$110	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*	
D3430	Retrograde filling - per root	$90	$90		
D3450	Root amputation - per root	Not covered	$110		
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	Not covered		
D3920	Hemisection (including	Not	$120		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	any root removal), not including root canal therapy	covered			
D3950	Canal preparation and fitting of preformed dowel or post	Not covered	$60		
D3999	Unspecified endodontic procedure, by report	$100	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	
D4000-D4999 V. PERIODONTICS					
- Includes 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	$150	$150	*1 per quadrant in 36 months, age 13+*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50	*1 per quadrant in 36 months, age 13+*	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not covered	$135		
D4241	Gingival flap procedure, including root planing - one to	Not covered	$70		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	three contiguous teeth or tooth bounded spaces per quadrant				
D4249	Clinical crown lengthening - hard tissue	$165	Not covered		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$265	$265	*1 per quadrant in 36 months, age 13+*	
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$140	$140	*1 per quadrant in 36 months, age 13+*	
D4263	Bone replacement graft - first site in quadrant	Not covered	$105		
D4264	Bone replacement graft - each additional site in quadrant	Not covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	Not covered		
D4266	Guided tissue regeneration - resorbable barrier, per site	Not covered	$145		
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not covered	$175		
D4270	Pedicle soft tissue graft procedure	Not covered	$155		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first	Not covered	$220		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	tooth, implant, or edentulous tooth position in graft				
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	$55	*1 per quadrant in 24 months; age 13+*	*4 quadrants during any 12 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	$25	*1 per quadrant in 24 months; age 13+*	*4 quadrants during any 12 consecutive months*
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40	$40	*1 treatment in any 12 consecutive months*	*1 treatment in any 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$10	Not covered		
D4910	Periodontal maintenance	$30	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*	*2 treatments each 12 month period*
D4910	Periodontal maintenance	Not covered	$45		*Up to 2 additional treatments within the 12 month period*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	Not covered	*1 per Contract Dentist; age 13+*	
D4921	Gingival irrigation - per quadrant	Not covered	No charge		
D4999	Unspecified periodontal procedure, by report	$350	Not covered	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.					
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.					
D5110	Complete denture - maxillary	$300	$400	*1 per 60 months*	
D5120	Complete denture - mandibular	$300	$400	*1 per 60 months*	
D5130	Immediate denture - maxillary	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	
D5140	Immediate denture - mandibular	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300	$325	*1 per 60 months*	
D5212	Mandibular partial denture - resin base (including any conventional clasps,	$300	$325	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	rests and teeth)				
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	$375	*1 per 60 months*	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	$375	*1 per 60 months*	
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not covered	$375		
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not covered	$375		
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Not covered	$250		
D5410	Adjust complete denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*	
D5411	Adjust complete denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*	
D5421	Adjust partial denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*	
D5422	Adjust partial denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				Contract Dentist after the initial 6 months	
D5510	Repair broken complete denture base	$40	$30	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*	
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	$30	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch in 12 months per Contract Dentist*	
D5610	Repair resin denture base	$40	$30	*1 per arch, per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*	
D5620	Repair cast framework	$40	$35	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*	
D5630	Repair or replace broken clasp - per tooth	$50	$30	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist.*	
D5640	Replace broken teeth - per tooth	$35	$30	*4 per arch per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*	
D5650	Add tooth to existing partial denture	$35	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*	
D5660	Add clasp to existing partial denture - per tooth	$60	$45	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*	
D5670	Replace all teeth and	Not	$195		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	acrylic on cast metal framework (maxillary)	covered			
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not covered	$195		
D5710	Rebase complete maxillary denture	Not covered	$155		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not covered	$155		*1 per 12 months*
D5720	Rebase maxillary partial denture	Not covered	$150		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not covered	$150		*1 per 12 months*
D5730	Reline complete maxillary denture (chairside)	$60	$80	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (chairside)	$60	$80	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (chairside)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (chairside)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (laboratory)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (laboratory)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5760	Reline maxillary partial denture (laboratory)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (laboratory)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5850	Tissue conditioning, maxillary	$30	$35	*2 per prosthesis in a 36-month period after*	*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				the initial 6 months	
D5851	Tissue conditioning, mandibular	$30	$35	*2 per prosthesis in a 36-month period after the initial 6 months*	*1 per 12 months*
D5862	Precision attachment, by report	$90	Not covered	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist or dental office.*	
D5863	Overdenture – complete maxillary	$300	Not covered	*1 in 60 months*	
D5865	Overdenture – complete mandibular	$300	Not covered	*1 in 60 months*	
D5899	Unspecified removable prosthodontic procedure, by report	$350	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS					
- All maxillofacial prosthetic procedures require prior authorization.					
D5911	Facial moulage (sectional)	$285	Not covered		
D5912	Facial moulage (complete)	$350	Not covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5913	Nasal prosthesis	$350	Not covered		
D5914	Auricular prosthesis	$350	Not covered		
D5915	Orbital prosthesis	$350	Not covered		
D5916	Ocular prosthesis	$350	Not covered		
D5919	Facial prosthesis	$350	Not covered		
D5922	Nasal septal prosthesis	$350	Not covered		
D5923	Ocular prosthesis, interim	$350	Not covered		
D5924	Cranial prosthesis	$350	Not covered		
D5925	Facial augmentation implant prosthesis	$200	Not covered		
D5926	Nasal prosthesis, replacement	$200	Not covered		
D5927	Auricular prosthesis, replacement	$200	Not covered		
D5928	Orbital prosthesis, replacement	$200	Not covered		
D5929	Facial prosthesis, replacement	$200	Not covered		
D5931	Obturator prosthesis, surgical	$350	Not covered		
D5932	Obturator prosthesis, definitive	$350	Not covered		
D5933	Obturator prosthesis, modification	$150	Not covered	*2 in 12 months*	
D5934	Mandibular resection prosthesis with guide flange	$350	Not covered		
D5935	Mandibular resection prosthesis without guide flange	$350	Not covered		
D5936	Obturator prosthesis, interim	$350	Not covered		
D5937	Trismus appliance (not for TMD treatment)	$85	Not covered		
D5951	Feeding aid	$135	Not covered		
D5952	Speech aid prosthesis, pediatric	$350	Not covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5953	Speech aid prosthesis, adult	$350	Not covered		
D5954	Palatal augmentation prosthesis	$135	Not covered		
D5955	Palatal lift prosthesis, definitive	$350	Not covered		
D5958	Palatal lift prosthesis, interim	$350	Not covered		
D5959	Palatal lift prosthesis, modification	$145	Not covered	*2 in 12 months*	
D5960	Speech aid prosthesis, modification	$145	Not covered	*2 in 12 months*	
D5982	Surgical stent	$70	Not covered		
D5983	Radiation carrier	$55	Not covered		
D5984	Radiation shield	$85	Not covered		
D5985	Radiation cone locator	$135	Not covered		
D5986	Fluoride gel carrier	$35	Not covered		
D5987	Commissure splint	$85	Not covered		
D5988	Surgical splint	$95	Not covered		
D5991	Vesiculobullous disease medicament carrier	$70	Not covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				pertinent history and the actual treatment.	
D6000-D6199 VIII. IMPLANT SERVICES					
- A Benefit only under exceptional medical conditions. Prior authorization is required. Refer also to Schedule B.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6040	Surgical placement: eposteal implant	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6050	Surgical placement: transosteal implant	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6055	Connecting bar – implant supported or abutment supported	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6056	Prefabricated abutment – includes modification and placement	$135	Not covered	*A Benefit only under exceptional medical conditions.*	
D6057	Custom fabricated abutment – includes placement	$180	Not covered	*A Benefit only under exceptional medical conditions.*	
D6058	Abutment supported porcelain/ceramic crown	$320	Not covered	*A Benefit only under exceptional medical conditions.*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not covered	*A Benefit only under exceptional medical conditions.*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not covered	*A Benefit only under exceptional medical conditions.*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not covered	*A Benefit only under exceptional medical conditions.*	
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not covered	*A Benefit only under exceptional medical conditions.*	
D6063	Abutment supported cast metal crown (predominantly base	$300	Not covered	*A Benefit only under exceptional medical conditions.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	metal)				
D6064	Abutment supported cast metal crown (noble metal)	$315	Not covered	*A Benefit only under exceptional medical conditions.*	
D6065	Implant supported porcelain/ceramic crown	$340	Not covered	*A Benefit only under exceptional medical conditions.*	
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335	Not covered	*A Benefit only under exceptional medical conditions.*	
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340	Not covered	*A Benefit only under exceptional medical conditions.*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not covered	*A Benefit only under exceptional medical conditions.*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not covered	*A Benefit only under exceptional medical conditions.*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not covered	*A Benefit only under exceptional medical conditions.*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not covered	*A Benefit only under exceptional medical conditions.*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not covered	*A Benefit only under exceptional medical conditions.*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not covered	*A Benefit only under exceptional medical conditions.*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not covered	*A Benefit only under exceptional medical conditions.*	
D6075	Implant supported retainer for ceramic FPD	$335	Not covered	*A Benefit only under exceptional medical conditions.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330	Not covered	*A Benefit only under exceptional medical conditions.*	
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	Not covered	*A Benefit only under exceptional medical conditions.*	
D6090	Repair implant supported prosthesis, by report	$65	Not covered	*A Benefit only under exceptional medical conditions.*	
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	Not covered	*A Benefit only under exceptional medical conditions.*	
D6092	Re-cement or re-bond implant/abutment supported crown	$25	Not covered	*A Benefit only under exceptional medical conditions.*	
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	Not covered	*A Benefit only under exceptional medical conditions.*	
D6094	Abutment supported crown - (titanium)	$295	Not covered	*A Benefit only under exceptional medical conditions.*	
D6095	Repair implant abutment, by report	$65	Not covered	*A Benefit only under exceptional medical conditions.*	
D6100	Implant removal, by report	$110	Not covered	*A Benefit only under exceptional medical conditions.*	
D6110	Implant /abutment	$350	Not	*A Benefit only under*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	supported removable denture for edentulous arch – maxillary		covered	*exceptional medical conditions.*	
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$350	Not covered	*A Benefit only under exceptional medical conditions.*	
D6190	Radiographic/surgical implant index, by report	$75	Not covered	*A Benefit only under exceptional medical conditions.*	
D6194	Abutment supported retainer crown for FPD (titanium)	$265	Not covered	*A Benefit only under exceptional medical conditions.*	
D6199	Unspecified implant procedure, by report	$350	Not covered	*Implant services are a Benefit only when exceptional medical conditions are documented and shall*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.	
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.					
D6205	Pontic - indirect resin based composite	Not covered	$165		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not covered	$300		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6212	Pontic - cast noble metal	Not covered	$300		*1 per 60 months*
D6214	Pontic - titanium	Not covered	$300		*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	Not covered	$300		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not covered	$300		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not covered	$300		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6252	Pontic - resin with noble metal	Not covered	$300		*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed	Not covered	$130		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	prosthesis				
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not covered	$145		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not covered	$200		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not covered	$200		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not covered	$200		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not covered	$200		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not covered	$200		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not covered	$200		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not covered	$200		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not covered	$200		*1 per 60 months*
D6634	Retainer onlay - titanium	Not covered	$200		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not covered	$200		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not covered	$300		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not covered	$300		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6751	Retainer crown - porcelain fused to	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	predominantly base metal				
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not covered	$300		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$40	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	$95		
D6999	Unspecified fixed prosthodontic procedure, by report	$350	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				Not a benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.	
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Prior authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.					
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.					
D7111	Extraction, coronal remnants - deciduous tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	$65		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	$115		
D7220	Removal of impacted tooth - soft tissue	$95	$85		
D7230	Removal of impacted tooth - partially bony	$145	$145		
D7240	Removal of impacted tooth - completely bony	$160	$160		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	$175		
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80	$75		
D7260	Oroantral fistula closure	$280	$280		
D7261	Primary closure of a sinus perforation	$285	Not covered		
D7270	Tooth reimplantation and/or stabilization of	$185	Not covered	*1 per arch regardless of number of teeth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	accidentally evulsed or displaced tooth			*involved; permanent anterior teeth*	
D7280	Surgical access of an unerupted tooth	$220	Not covered		
D7283	Placement of device to facilitate eruption of impacted tooth	$85	Not covered	*For active orthodontic treatment only*	
D7285	Incisional biopsy of oral tissue -hard (bone, tooth)	$180	Not covered	*1 per arch per date of service; regardless of number of areas involved*	
D7286	Incisional biopsy of oral tissue -soft	$110	$110	*3 per date of service*	
D7287	Exfoliative cytological sample collection	Not covered	$35		
D7288	Brush biopsy - transepithelial sample collection	Not covered	$35		
D7290	Surgical repositioning of teeth	$185	Not covered	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	Not covered	*1 per arch; applies to active orthodontic treatment*	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	$85		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	$50		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	$120		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	$65		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	Not covered	*1 per arch per 60 months*	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	Not covered	*1 per arch*	
D7410	Excision of benign lesion up to 1.25 cm	$75	Not covered		
D7411	Excision of benign lesion greater than 1.25 cm	$115	Not covered		
D7412	Excision of benign lesion, complicated	$175	Not covered		
D7413	Excision of malignant lesion up to 1.25 cm	$95	Not covered		
D7414	Excision of malignant lesion greater than 1.25 cm	$120	Not covered		
D7415	Excision of malignant lesion, complicated	$255	Not covered		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	Not covered		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	Not covered		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	Not covered		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	Not covered		
D7460	Removal of benign nonodontogenic cyst	$155	Not covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	or tumor - lesion diameter up to 1.25 cm				
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	Not covered		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	Not covered		
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140	*1 per quadrant*	
D7472	Removal of torus palatinus	$145	$140	*1 per lifetime*	
D7473	Removal of torus mandibularis	$140	$140	*1 per quadrant*	
D7485	Surgical reduction of osseous tuberosity	$105	Not covered	*1 per quadrant*	
D7490	Radical resection of maxilla or mandible	$350	Not covered		
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	$55	*1 per quadrant per date of service*	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	$69	*1 per quadrant per date of service*	
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	Not covered		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	Not covered		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	Not covered	*1 per date of service*	
D7540	Removal of reaction	$75	Not	*1 per date of service*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	producing foreign bodies, musculoskeletal system		covered		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	$125	*1 per quadrant per date of service*	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	Not covered		
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	Not covered		
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	Not covered		
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	Not covered		
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	Not covered		
D7650	Malar and/or zygomatic arch - open reduction	$350	Not covered		
D7660	Malar and/or zygomatic arch - closed reduction	$350	Not covered		
D7670	Alveolus - closed reduction may include stabilization of teeth	$170	Not covered		
D7671	Alveolus - open reduction may include stabilization of teeth	$230	Not covered		
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	Not covered		
D7710	Maxilla - open	$110	Not		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	reduction		covered		
D7720	Maxilla - closed reduction	$180	Not covered		
D7730	Mandible - open reduction	$350	Not covered		
D7740	Mandible - closed reduction	$290	Not covered		
D7750	Malar and/or zygomatic arch - open reduction	$220	Not covered		
D7760	Malar and/or zygomatic arch - closed reduction	$350	Not covered		
D7770	Alveolus - open reduction stabilization of teeth	$135	Not covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	Not covered		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	Not covered		
D7810	Open reduction of dislocation	$350	Not covered		
D7820	Closed reduction of dislocation	$80	Not covered		
D7830	Manipulation under anesthesia	$85	Not covered		
D7840	Condylectomy	$350	Not covered		
D7850	Surgical discectomy, with/without implant	$350	Not covered		
D7852	Disc repair	$350	Not covered		
D7854	Synovectomy	$350	Not covered		
D7856	Myotomy	$350	Not covered		
D7858	Joint reconstruction	$350	Not covered		
D7860	Arthrotomy	$350	Not covered		
D7865	Arthroplasty	$350	Not covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7870	Arthrocentesis	$90	Not covered		
D7871	Non-arthroscopic lysis and lavage	$150	Not covered		
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	Not covered		
D7873	Arthroscopy - surgical: lavage and lysis of adhesions	$350	Not covered		
D7874	Arthroscopy - surgical: disc repositioning and stabilization	$350	Not covered		
D7875	Arthroscopy - surgical: synovectomy	$350	Not covered		
D7876	Arthroscopy - surgical: discectomy	$350	Not covered		
D7877	Arthroscopy - surgical: debridement	$350	Not covered		
D7880	Occlusal orthotic device, by report	$120	Not covered		
D7899	Unspecified TMD therapy, by report	$350	Not covered		
D7910	Suture of recent small wounds up to 5 cm	$35	Not covered		
D7911	Complicated suture - up to 5 cm	$55	Not covered		
D7912	Complicated suture - greater than 5 cm	$130	Not covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not covered		
D7940	Osteoplasty - for orthognathic deformities	$160	Not covered		
D7941	Osteotomy - mandibular rami	$350	Not covered		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	Not covered		
D7944	Osteotomy - segmented or subapical	$275	Not covered		
D7945	Osteotomy - body of	$350	Not		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	mandible		covered		
D7946	Lefort I (maxilla - total)	$350	Not covered		
D7947	Lefort I (maxilla - segmented)	$350	Not covered		
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	Not covered		
D7949	Lefort II or lefort III - with bone graft	$350	Not covered		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	Not covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not covered		
D7952	Sinus augmentation via a vertical approach	$175	Not covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not covered		
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$120	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*	
D7963	Frenuloplasty	$120	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*	
D7970	Excision of hyperplastic tissue - per arch	$175	$176	*1 per arch per date of service*	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of	$100	Not	*1 per quadrant per date*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	fibrous tuberosity		covered	*of service*	
D7980	Sialolithotomy	$155	Not covered		
D7981	Excision of salivary gland, by report	$120	Not covered		
D7982	Sialodochoplasty	$215	Not covered		
D7983	Closure of salivary fistula	$140	Not covered		
D7990	Emergency tracheotomy	$350	Not covered		
D7991	Coronoidectomy	$345	Not covered		
D7995	Synthetic graft - mandible or facial bones, by report	$150	Not covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not covered	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D7999	Unspecified oral surgery procedure, by report	$350	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY					
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.					
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.					
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.					
- Refer to Schedule B for additional information on Medically Necessary Orthodontics.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	Not covered	*1 per Enrollee per phase of treatment*	
D8210	Removable appliance therapy			*1 per lifetime; age 6 through 12*	
D8220	Fixed appliance therapy			*1 per lifetime; age 6 through 12*	
D8660	Pre-orthodontic treatment examination to monitor growth and development			*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*	
D8670	Periodic orthodontic treatment visit			*1 per 3 months; included in comprehensive case fee*	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))			*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*	
D8691	Repair of orthodontic appliance			*1 per appliance; included in comprehensive case fee*	
D8692	Replacement of lost or broken retainer			*1 per arch; within 24 months following the date of service for orthodontic retention*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				(D8680)	
D8693	Re-cement or re-bond fixed retainer			*1 per Contract Dentist; included in comprehensive case fee*	
D8999	Unspecified orthodontic procedure, by report			*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	$28	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*	
D9120	Fixed partial denture sectioning	$95	$95		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with	$15	$15		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	operative or surgical procedures				
D9223	Deep sedation/general anesthesia – each 15 minute increment	$45	$45	*Covered only when given by a Contract Dentist for covered oral surgery*	
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	$15	Not covered	*(Where available)*	
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	See D9243	See D9243	*Refer to D9243 for copayment and billing*	
D9242	ravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	See D9243	See D9243	*Refer to D9243 for copayment and billing*	
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$60	$45	*Covered only when given by a Contract Dentist for covered oral surgery*	
D9248	Non-intravenous conscious sedation	$65	Not covered	*Where available; 1 per date of service per Contract Dentist*	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	$45		
D9410	House/extended care facility call	$50	Not covered	*1 per Enrollee per date of service*	
D9420	Hospital or ambulatory surgical center call	$135	Not covered		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	$12	*1 per date of service per Contract Dentist*	
D9440	Office visit - after regularly scheduled hours	$45	$40	*1 per date of service per Contract Dentist*	
D9450	Case presentation, detailed and extensive	Not covered	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
	treatment planning				
D9610	Therapeutic parenteral drug, single administration	$30	Not covered	*4 of (D9610, D9612) injections per date of service*	
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	Not covered	*4 of (D9610, D9612) injections per date of service*	
D9910	Application of desensitizing medicament	$20	$22	*1 in 12 months per Contract Dentist; permanent teeth*	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	Not covered	*1 per date of service per Contract Dentist within 30 days of an extraction*	
D9940	Occlusal guard, by report	Not covered	$115		*1 in 3 years*
D9942	Repair and/or reline of occlusal guard	Not covered	$35		
D9950	Occlusion analysis - mounted case	$120	Not covered	*Prior authorization is required; 1 in 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9951	Occlusal adjustment - limited	$45	$45	*1 in 12 months for quadrant per Contract Dentist; age 13+*	
D9952	Occlusal adjustment - complete	$210	$210	*1 in 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9999	Unspecified adjunctive procedure, by report	No charge	Not covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.	

Endnotes:

Base metal is the Benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B, Limitations and Exclusions of Benefits* for additional information.

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 the plan. The Enrollee pays the Copayment specified for such services.

Procedures not listed above or noted as "not covered" are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" mean the Contract Dentist's fees on file with the plan. Questions regarding these fees should be directed to the Customer Service Center at 800-471-7583.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the DeltaCare USA dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the DeltaCare USA Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Copayment for the covered procedure.

Additional Endnotes to Covered California's 2017 Dental Standard Benefit Plan Designs

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

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached. *(Not applicable to Children's Dental HMO.)*

2) Deductible is waived for Diagnostic and Preventive Services. *(Not applicable to Children's Dental HMO.)*

3) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.

4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.

5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum. *(Not applicable to Children's Dental HMO.)*

6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.

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

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

9) Each adult is responsible for an individual deductible. (*Not applicable to Family Dental HMO.)*

10) Deductible is waived for Diagnostic and Preventive Services. (*Not applicable to Family Dental HMO.)*

11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.

12) Tooth whitening, adult orthodontia and implants are not covered services.

SCHEDULE B
Limitations and Exclusions of Benefits
Delta Dental of California
Family Dental HMO

Limitations and Exclusions of Benefits for Adult Enrollees (Age 19 and older)

<u>Limitations of Benefits for Adult Enrollees</u>

1. The frequency of certain Benefits is limited. 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 $125 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. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Contact the Customer Service Center at 800-471-7583 if you have questions regarding the additional fee or name brand services.

5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

6. 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 or office where the denture was originally delivered.

7. Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.
8. 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.

   Exception to extend covered orthodontics Benefits to a cancelled or terminated Policy is as

follows:

a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), 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.

4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures as shown on *Schedule A*.

6. 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.

7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

8. Consultations or other diagnostic services for non-covered Benefits.

9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

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

11. Prescription and over-the-counter drugs.

12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for

crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

13. Changes in orthodontic treatment necessitated by accident of any kind.

14. Myofunctional and parafunctional appliances and/or therapies, with the exception of as procedures shown on *Schedule A*

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

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

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

<u>Limitations of Benefits for Pediatric Enrollees</u>

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

4. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.

5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**

   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, **or**
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

6. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture :

   a. Fixed partial denture (bridge):
      - A fixed partial denture is a benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**

- The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, **or**
- Each abutment tooth to be crowned meets Limitation #3.

b. Removable partial denture:
- Cast metal (D5213, D5214), one or more teeth are missing in an arch.
- Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

7. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.

8. Excision of the frenum is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

9. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on *Schedule A*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

10. A new removable partial or complete or covered immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

11. Immediate dentures are covered when one or more of the following conditions are present:

    a. Extensive or rampant caries are exhibited in the radiographs, **or**

    b. Severe periodontal involvement indicated, **or**

    c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

12. Maxillofacial prosthetic services for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

13. All maxillofacial prosthetic procedures require prior authorization for medically necessary procedures.

14. Implant services are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.

    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the Enrollee is unable to function with conventional prosthesis.

    c. Skeletal deformities that preclude the use of conventional prosthesis (such as

arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

15. Temporomandibular joint dysfunction procedure codes D7810-D7880 are limited to differential diagnosis and symptomatic care and require prior authorization.

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

17. Deep sedation/general anesthesia or intravenous conscious sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

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

3. Lost or theft of full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) or other appliances.

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

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

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

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

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**

   b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call the Customer Service Center at 800-471-7583.

10. Consultations or other diagnostic services for non-covered Benefits.

11. Single tooth implants.

12. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures are not a Benefit to replace missing 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ), unless included in *Schedule A*.

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the prepaid dental program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.

17. 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.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

19. Temporomandibular joint dysfunction treatment modalities that involve prosthodontia, orthodontia, and full or partial occlusal rehabilitation or TMJ dysfunction procedures solely for the treatment of bruxism.

20. Vestibuloplasty / ridge extension procedures performed on the same date of service as extractions (D7111-D7250) on the same arch.

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

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

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

24. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

25. Cosmetic dental care.

26. Experimental or investigational procedures.

27. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.

28. Major surgery for fractures and dislocations.

29. Additional treatment costs incurred because a dental procedure is unable to be performed in the Contract Dentist's office due to the general health and physical limitations of the Enrollee.

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts. Comprehensive orthodontic treatment:
   a. is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b. may start at birth for patients with a cleft palate or craniofacial anomaly.

2. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

3. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0351). Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment examination.

4. The number of covered periodic orthodontic treatment visits and length of covered active orthodontics is limited to a maximum of up to:
   a. Handicapping malocclusion - Eight (8) quarterly visits;
   b. Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;
   c. Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or
   d. Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.
   e. Facial growth management – Four (4) quarterly visits for treatment of primary dentition;
   f. Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;
   g. Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment which:
   a. Includes removal of appliances and the construction and place of retainer(s); and

b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and

   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

   a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

   b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

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

SCHEDULE C

Information Concerning Benefits Under The DeltaCare USA Plan

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

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Annual Out-of-Pocket Maximum	Individual $350.00 Multiple Child $700.00
(D) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Schedule of Benefits and Copayments, subject to the limitations and exclusions of the Program. Copayments range by category of service. Examples are as follows: Diagnostic Services: No Cost Preventive Services: No Cost Restorative Services: $ 20.00 - $ 310.00 Endodontic Services: $ 20.00 - $ 365.00 Periodontic Services: $ 10.00 - $ 265.00 Prosthodontic Services, Removable: $ 20.00 - $ 335.00 Maxillofacial Prosthetics: $ 35.00 - $ 350.00 Implant Services (medically necessary only): $ 25.00 - $ 350.00 Prosthodontic Services, Fixed: $ 30.00 - $ 300.00 Oral and Maxillofacial Surgery: $ 25.00 - $ 350.00 Orthodontic Services (medically necessary only): No Cost - $ 350.00 Adjunctive General Services: No Cost - $ 210.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to two (2) in a 12 month period; Replacement of a crown is limited to once every thirty-six (36) consecutive months for Pediatric Enrollees and once every sixty (60) consecutive months for Adult Enrollees.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

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

POLICY INFORMATION

Information in this Attachment is variable.

Policyholder: [Insert Name]

Effective Date: [Insert Effective Date]

Policy Year: [Insert Policy Year]

Policy ID Number: [Insert Policy Number]

Premium Remittance:

[Each[D1] Premium is to be paid to the MPI. Please contact MPI for the appropriate remittance address.]

[Each[D2] Premium is to be paid to the Exchange. Please contact the Exchange for the appropriate remittance address.]

[Each [D3]Premium is to be paid to:
Delta Dental Insurance Company
P.O. Box 660138
Dallas, TX 75266-0138]

Monthly Premium:

[XXXX]