DeltaCare® USA

Dental HMO Program

Plan CAM57

Combined Evidence of Coverage and Disclosure Form

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

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234
This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare Dental Health Care Program ("Program") provided by Delta Dental of California ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

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

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

A STATEMENT DESCRIBING DELTA DENTAL OF CALIFORNIA’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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

The telephone number at which you may obtain information about benefits is 800-422-4234.
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Definitions
As used in this booklet:

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

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

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

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

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

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

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

**Emergency Service** means 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: (i) placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

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

**Open Enrollment Period** means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.
Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

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

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

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

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics or periodontics and which must be preauthorized in writing by Delta Dental.

Treatment In Progress means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established and full or partial dentures for which an impression has been taken.

We, Us or Our means Delta Dental of California or the Administrator as appropriate.
Eligibility for Benefits
Individual adults who meet the eligibility requirements defined by the Client are eligible for coverage under the DeltaCare USA Dental HMO Program. Dependent coverage is not available under this Program.

Prepayment Fees/Premiums
This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist
To enroll in this Program, you must select a Contract Dentist from the list of Contract Dentists. You must indicate the Contract Dentist's name and Contract Dentist facility ID# on the enrollment form. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.
YOU MUST GO TO YOUR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN EMERGENCY SERVICES. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

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

**Continuity of Care**

Current Members:

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

New Members:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.
Special Needs
If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

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

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

Copayments and Other Charges
You are required to pay any Copayments listed in the Description of Benefits and Copayments directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the Description of Benefits and Copayments.

Emergency Services
If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact Delta Dental's Customer Service department at 800-422-4234 for help in locating a Contract Dentist. Benefits for Emergency Services
by an Out-of-Network Dentist are 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.

Benefits for Emergency Services not provided by the Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Contract Dentist.

**Specialist Services**

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

**Second Opinion**

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of 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 department at 800-422-4234 or write to Delta Dental.

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

Claims for Reimbursement
Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

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

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

**You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.**

**Processing Policies**

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

**Coordination of Benefits**

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

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

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

An Enrollee shall provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

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

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 identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental at least 180 days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of
whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, 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 regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves 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 complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-422-4234 and use your health plan's grievance process.
before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, 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 Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

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

Renewal and Termination of Benefits
This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person
ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

**Cancellation of Enrollment**

Subject to any continued coverage option, an Eligible Employee's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately upon loss of eligibility as described in this Evidence of Coverage; or

2) Upon 15 days written notice if:
   a) an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
   b) the premiums are not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 30-day grace period and may be reinstated during the term of this Program upon payment of any unpaid premium; or
   c) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;

3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges.

Any cancellation is subject to the written notification requirements set forth in this Contract.
If you believe that enrollment has been cancelled or not renewed because of your health status or requirements for health care services, you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to *Appeals Procedure* on pages 7-9.

**Governing Law**
This Program is a health care service plan subject to the requirements of Chapter 22 of Division 2 of the California Health & Safety Code and Chapter 1 of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be included in this Disclosure Form/Contract by the above law and regulation binds this Program whether or not stated.

**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.
SCHEDULE A
Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2017 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Enrollee Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100-D0999</td>
<td>I. DIAGNOSTIC</td>
<td></td>
</tr>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient .....................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused .........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient .......................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report .............</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation - post-operative office visit .....................................</td>
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</tr>
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<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient ................</td>
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</tr>
<tr>
<td>D0190</td>
<td>Screening of a patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0191</td>
<td>Assessment of a patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images - <em>limited to 1 series every 36 months</em></td>
<td>No Cost</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image .....................................</td>
<td>No Cost</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Cost</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images</td>
<td>No Cost</td>
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<tr>
<td>D0273</td>
<td>Bitewings three radiographic images</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four radiographic images - limited to 1 series every 6 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image - limited to 1 each 36 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
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<tr>
<td>D0472</td>
<td>Accession of tissue, gross examination, preparation and transmission of</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>written report</td>
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<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>transmission of written report</td>
<td></td>
</tr>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination, including assessment</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>of surgical margins for presence of disease, preparation and transmission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of written report</td>
<td></td>
</tr>
<tr>
<td>D0601</td>
<td>Caries risk assessment and documentation, with a finding of low risk</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>1 every 3 years</td>
<td></td>
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<tr>
<td>D0602</td>
<td>Caries risk assessment and documentation, with a finding of moderate risk</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>1 every 3 years</td>
<td></td>
</tr>
<tr>
<td>D0603</td>
<td>Caries risk assessment and documentation, with a finding of high risk</td>
<td>No Cost</td>
</tr>
<tr>
<td></td>
<td>1 every 3 years</td>
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</tr>
<tr>
<td>D0999</td>
<td>Unspecified diagnostic procedure, by report - includes office visit, per</td>
<td>$5.00</td>
</tr>
<tr>
<td></td>
<td>visit (in addition to other services)</td>
<td></td>
</tr>
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**II. PREVENTIVE**

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period</td>
<td>$15.00</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for control of dental disease</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions</td>
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</tbody>
</table>
### III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
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<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
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<td>Amalgam - two surfaces, primary or permanent</td>
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<td>Amalgam - three surfaces, primary or permanent</td>
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<td>Amalgam - four or more surfaces, primary or permanent</td>
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<td>Resin-based composite - one surface, anterior</td>
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<td>Resin-based composite - two surfaces, anterior</td>
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<td>Resin-based composite - three surfaces, anterior</td>
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<td>Resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
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<td>Resin-based composite - one surface, posterior</td>
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<td>Resin-based composite - two surfaces, posterior</td>
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<td>Resin-based composite - three surfaces, posterior</td>
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<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior</td>
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<td>D2652</td>
<td>Inlay - resin-based composite - three or more surfaces 1, 6</td>
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<td>D2662</td>
<td>Onlay - resin-based composite - two surfaces 1, 6</td>
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<tr>
<td>D2663</td>
<td>Onlay - resin-based composite - three surfaces</td>
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<tr>
<td>D2664</td>
<td>Onlay - resin-based composite - four or more surfaces</td>
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<td>Crown - resin-based composite (indirect)</td>
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<td>Crown - ¾ resin-based composite (indirect)</td>
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<td>D2720</td>
<td>Crown - resin with high noble metal</td>
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<td>Crown - resin with predominantly base metal</td>
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<td>Crown - resin with noble metal</td>
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<td>Crown - porcelain/ceramic substrate</td>
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<td>Crown - porcelain fused to high noble metal</td>
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<td>Crown - porcelain fused to predominantly base metal</td>
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<td>Crown - ¾ cast high noble metal</td>
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<td>Crown - ¾ cast predominantly base metal</td>
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<tr>
<td>D2782</td>
<td>Crown - ¾ cast noble metal</td>
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<td>D2790</td>
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<td>D2794</td>
<td>Crown - titanium</td>
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<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
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<tr>
<td>D2915</td>
<td>Re-cement or re-bond indirectly fabricated or prefabricated post and core</td>
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<td>Re-cement or re-bond crown</td>
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<td>D2921</td>
<td>Reattachment of tooth fragment, incisal edge or cusp (anterior)</td>
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<td>D2932</td>
<td>Prefabricated resin crown</td>
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<td>D2940</td>
<td>Protective restoration</td>
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<td>D2941</td>
<td>Interim therapeutic restoration</td>
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<td>D2949</td>
<td>Restorative foundation for an indirect restoration</td>
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<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required</td>
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<tr>
<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
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<tr>
<td>D2952</td>
<td>Post and core in addition to crown, indirectly fabricated - includes canal preparation (2nd)</td>
<td>$95.00</td>
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<td>Description</td>
<td>Cost</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>D2953</td>
<td>Each additional indirectly fabricated post - same tooth - <em>includes canal preparation</em></td>
<td>$95.00</td>
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<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown - <em>base metal post; includes canal preparation</em></td>
<td>$70.00</td>
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<tr>
<td>D2957</td>
<td>Each additional prefabricated post - same tooth - <em>base metal post; includes canal preparation</em></td>
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<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure</td>
<td>$45.00</td>
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<tr>
<td>D2981</td>
<td>Inlay repair necessitated by restorative material failure</td>
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<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
<td>$45.00</td>
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<tr>
<td>D2983</td>
<td>Veneer repair necessitated by restorative material failure</td>
<td>$45.00</td>
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### IV. ENDODONTICS

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<th>Code</th>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>No Cost</td>
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<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
<td>$35.00</td>
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<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3310</td>
<td><em>Root canal</em> - endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>$180.00</td>
</tr>
<tr>
<td>D3320</td>
<td><em>Root canal</em> - endodontic therapy, bicuspid tooth (excluding final restoration)</td>
<td>$230.00</td>
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<tr>
<td>D3330</td>
<td><em>Root canal</em> - endodontic therapy, molar (excluding final restoration)</td>
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<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior</td>
<td>$280.00</td>
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<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - bicuspid</td>
<td>$330.00</td>
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<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar</td>
<td>$475.00</td>
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<tr>
<td>D3410</td>
<td>Apicoectomy - anterior</td>
<td>$270.00</td>
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<tr>
<td>D3421</td>
<td>Apicoectomy - bicuspid (first root)</td>
<td>$335.00</td>
</tr>
</tbody>
</table>
D3425 Apicoectomy - molar (first root) .......................... $380.00
D3426 Apicoectomy (each additional root) ....................... $105.00
D3427 Periradicular surgery without apicoectomy............. $270.00
D3430 Retrograde filling - per root .................................................. $25.00
D3450 Root amputation, per root - not covered in conjunction with a hemisection ........................................... $75.00

D4000-D4999 V. PERIODONTICS
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant................................................................. $300.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant................................................................. $50.00
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth .................................. $50.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant................................................................. $300.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant................................................................. $300.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant................................................................. $450.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant................................................................. $450.00
D4341 Periodontal scaling and root planing - four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months ..... $55.00
D4342 Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months ..... $55.00
### Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation

1. **D4346**
   - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 *D1110, D1120 or D4346 per 6 month period*  
   - **$15.00**

### Full mouth debridement to enable comprehensive evaluation and diagnosis

1. **D4355**
   - Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*  
   - **$55.00**

### Periodontal maintenance

1. **D4910**
   - Periodontal maintenance - *limited to 1 treatment each 6 month period*  
   - **$45.00**

### Gingival irrigation - per quadrant

1. **D4921**
   - Gingival irrigation - per quadrant  
   - **No Cost**

---

### VI. PROSTHODONTICS (removable)

#### Complete denture

1. **D5110**
   - Complete denture - maxillary  
   - **$395.00**

2. **D5120**
   - Complete denture - mandibular  
   - **$395.00**

3. **D5130**
   - Immediate denture - maxillary  
   - **$495.00**

4. **D5140**
   - Immediate denture - mandibular  
   - **$495.00**

5. **D5211**
   - Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)  
   - **$300.00**

6. **D5212**
   - Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)  
   - **$300.00**

7. **D5213**
   - Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  
   - **$395.00**

8. **D5214**
   - Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  
   - **$395.00**

9. **D5221**
   - Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)  
   - **$300.00**

10. **D5222**
    - Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)  
    - **$300.00**

11. **D5223**
    - Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  
    - **$395.00**
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ................................................................. $395.00

D5410 Adjust complete denture - maxillary 3 ......................... $20.00
D5411 Adjust complete denture - mandibular 3 ...................... $20.00
D5421 Adjust partial denture - maxillary 3 ......................... $20.00
D5422 Adjust partial denture - mandibular 3 ......................... $20.00
D5510 Repair broken complete denture base ..................... $50.00
D5520 Replace missing or broken teeth - complete denture (each tooth) ................................................................. $25.00

D5410 Adjust complete denture - maxillary 3 ......................... $20.00
D5411 Adjust complete denture - mandibular 3 ...................... $20.00
D5421 Adjust partial denture - maxillary 3 ......................... $20.00
D5422 Adjust partial denture - mandibular 3 ......................... $20.00
D5510 Repair broken complete denture base ..................... $50.00
D5520 Replace missing or broken teeth - complete denture (each tooth) ................................................................. $25.00

D5610 Repair resin denture base............................................ $50.00
D5620 Repair cast framework.................................................. $90.00
D5630 Repair or replace broken clasp - per tooth............... $45.00
D5640 Replace broken teeth - per tooth .................................. $25.00
D5650 Add tooth to existing partial denture ......................... $45.00
D5660 Add clasp to existing partial denture - per tooth..... $45.00
D5710 Rebase complete maxillary denture .......................... $130.00
D5711 Rebase complete mandibular denture ......................... $130.00
D5720 Rebase maxillary partial denture ............................. $130.00
D5721 Rebase mandibular partial denture ............................ $130.00
D5730 Reline complete maxillary denture (chairside) ......... $50.00
D5731 Reline complete mandibular denture (chairside) .... $50.00
D5740 Reline maxillary partial denture (chairside) ............ $50.00
D5741 Reline mandibular partial denture (chairside) .......... $50.00
D5750 Reline complete maxillary denture (laboratory) ...... $150.00
D5751 Reline complete mandibular denture (laboratory) .... $150.00
D5760 Reline maxillary partial denture (laboratory) .......... $150.00
D5761 Reline mandibular partial denture (laboratory) ....... $150.00
D5820 Interim partial denture (maxillary) - limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing 3 ................................................................. $55.00
D5821  Interim partial denture (mandibular) - *limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing* \(^3\) ........................... $55.00

D5850  Tissue conditioning, maxillary \(^{3,9}\) ........................ $30.00

D5851  Tissue conditioning, mandibular \(^{3,9}\) ........................ $30.00

D5863  Overdenture - complete maxillary ..........................Optional

D5864  Overdenture - partial maxillary .............................Optional

D5865  Overdenture - complete mandibular ..........................Optional

D5866  Overdenture - partial mandibular .............................Optional

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

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

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

D6210  Pontic - cast high noble metal \(^5\) ........................... $365.00

D6211  Pontic - cast predominantly base metal \(^5\) ................ $300.00

D6212  Pontic - cast noble metal \(^5\) ............................... $300.00

D6240  Pontic - porcelain fused to high noble metal \(^{5,8}\) .... $395.00

D6241  Pontic - porcelain fused to predominantly base metal \(^{5,8}\) ........................................................ $315.00

D6242  Pontic - porcelain fused to noble metal \(^{5,8}\) ........ $350.00

D6245  Pontic - porcelain/ceramic \(^1,5\) ..............................Optional

D6250  Pontic - resin with high noble metal \(^{5,8}\) ............. $395.00

D6251  Pontic - resin with predominantly base metal \(^{5,8}\) .. $315.00

D6252  Pontic - resin with noble metal \(^{5,8}\) ..................... $350.00

D6600  Retainer inlay - porcelain/ceramic, two surfaces \(^1,5\) .............................................Optional

D6601  Retainer inlay - porcelain/ceramic, three or more surfaces \(^1,5\) .................................Optional

D6602  Retainer inlay - cast high noble metal, two surfaces \(^2,5\) ........................................ $270.00

D6603  Retainer inlay - cast high noble metal, three or more surfaces \(^2,5\) ........................................ $280.00
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<tr>
<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
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<td>$280.00</td>
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<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
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<tr>
<td>D6607</td>
<td>Retainer inlay - cast noble metal, three or more surfaces</td>
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<tr>
<td>D6608</td>
<td>Retainer onlay - porcelain/ceramic, two surfaces</td>
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<td>D6609</td>
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<td>D6612</td>
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<td>D6613</td>
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<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
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<td>Retainer crown - porcelain fused to high noble metal</td>
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<td>Retainer crown - porcelain fused to predominantly base metal</td>
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<tr>
<td>D6781</td>
<td>Retainer crown - ¾ cast predominantly base metal</td>
<td>5</td>
<td>$300.00</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - ¾ cast noble metal</td>
<td>5</td>
<td>$335.00</td>
</tr>
</tbody>
</table>
D6790  Retainer crown - full cast high noble metal $365.00
D6791  Retainer crown - full cast predominantly base metal $300.00
D6792  Retainer crown - full cast noble metal $335.00
D6930  Re-cement or re-bond fixed partial denture $30.00
D6940  Stress breaker $50.00
D6980  Fixed partial denture repair necessitated by restorative material failure $45.00

D7000-D7999  X. ORAL AND MAXILLOFACIAL SURGERY
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111  Extraction, coronal remnants - deciduous tooth $35.00
D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal) $35.00
D7210  Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated $65.00
D7220  Removal of impacted tooth - soft tissue $75.00
D7230  Removal of impacted tooth - partially bony $100.00
D7240  Removal of impacted tooth - completely bony $140.00
D7241  Removal of impacted tooth - completely bony, with unusual surgical complications $160.00
D7250  Removal of residual tooth roots (cutting procedure) $65.00
D7251  CoronectomY - intentional partial tooth removal $160.00
D7286  Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures $60.00
D7310  Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant $50.00
D7311  Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant $50.00
D7320  Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant $105.00
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .......................................................... $105.00

D7471 Removal of lateral exostosis (maxilla or mandible) ........................................... $200.00

D7510 Incision and drainage of abscess - intraoral soft tissue .......................................................... $35.00

D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure .................................................. $75.00

D8000-D8999 XI. ORTHODONTICS - Not Covered

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain - minor procedure ........................................... $35.00

D9211 Regional block anesthesia ........................................... No Cost

D9212 Trigeminal division block anesthesia ........................................... No Cost

D9215 Local anesthesia in conjunction with operative or surgical procedures ........................................... No Cost

D9219 Evaluation for deep sedation or general anesthesia ........................................... No Cost

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician ........................................... $35.00

D9311 Consultation with medical health care professional ........................................... No Cost

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed ...... $5.00

D9440 Office visit - after regularly scheduled hours ............ $50.00

D9932 Cleaning and inspection of removable complete denture, maxillary ........................................... No Cost

D9933 Cleaning and inspection of removable complete denture, mandibular........................................... No Cost

D9934 Cleaning and inspection of removable partial denture, maxillary ........................................... No Cost

D9935 Cleaning and inspection of removable partial denture, mandibular........................................... No Cost
D9986 Missed appointment - without 24 hour notice
- per 15 minutes of appointment time - up to an
overall maximum of $40.00.......................... $10.00

D9987 Canceled appointment - without 24 hour notice
- per 15 minutes of appointment time - up to an
overall maximum of $40.00.......................... $10.00

D9991 Dental case management - addressing
appointment compliance barriers .................... No Cost

D9992 Dental case management - care coordination........ No Cost

FOOTNOTES

1 Optional is defined as any alternative procedure presented by
the Contract Dentist that satisfies the same dental need as a
covered procedure, is chosen by the Enrollee, and is subject to
the Limitations and Exclusions of the program. The applicable
charge to the Enrollee is the difference between the Contract
Dentist's "filed fee" for the Optional procedure and the "filed
fee" for the covered procedure, plus any applicable Copayment
for the covered procedure. "Filed fees" means the Contract
Dentist's fees on file with Delta Dental. Questions regarding
the DeltaCare USA program should be directed to Delta
Dental's Customer Service department at 800-422-4234.

2 Base or noble metal is the benefit. High noble metal (precious),
if used, will be charged to the Enrollee at the additional
maximum cost to the Enrollee of $100.00 per tooth. If an
indirectly fabricated post and core is made of high noble metal,
an additional fee up to $100.00 per tooth will be charged for
the upgrade. This charge also applies to a titanium crown.

3 Includes after delivery adjustments and tissue conditioning, if
needed, 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.

4 Replacement is subject to a limitation requiring the existing
denture to be 5+ years old.
5 Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.

6 Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.

7 A Benefit for permanent teeth only.

8 Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $75.00.

9 Limited to 1 per denture during any 12 consecutive months.
SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 36 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.

2. Bitewing x-rays are limited to not more than one series of four films in any six month period.

3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.

4. If a biopsy is preauthorized by Delta Dental for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.

5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.

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

7. 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 limitation (Limitation #11).

8. A covered metallic inlay or onlay using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
9. For molars, a covered crown or unit of a fixed partial denture (bridge) is a full cast metal restoration without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $75.00 per molar.

10. 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.

11. 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 prior to its replacement, **or**
      - If an existing partial denture is less than five years old, 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.

12. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.

13. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.

14. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
15. The benefit for the replacement of a missing posterior tooth (or teeth) is a removable partial denture. Coverage for the placement of a fixed partial denture (bridge) is optional except in the following cases:
   - The sole tooth to be replaced in the arch is a permanent anterior tooth, provided that it is not in conjunction with a partial denture on the same arch. A cantilever bridge is a benefit at the professional discretion of the Contract Dentist for the replacement of one missing permanent anterior tooth only; or
   - The new bridge would replace an existing, non-functional bridge utilizing the same abutment teeth, with no additional abutments or pontics with the exception of posterior cantilever bridges (see Limitation #11).
   - The abutment teeth are not being crowned solely for the purpose of supporting a pontic (each abutment tooth to be crowned must meet Limitation #7).

16. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.

17. 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.

18. 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.

19. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear,
will be covered as described in Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.

20. 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.

21. A new removable partial, complete or 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.

22. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fees" for the Optional procedure and the "filed fees" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. Optional procedures include:

- The use of a tooth-colored material when restoring a posterior tooth with a filling, inlay or onlay; and

- Units in a fixed partial denture (bridge) made of porcelain/ceramic, which is not fused to and supported by underlying cast metal.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.
Exclusions of Benefits

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

2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.

3. All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.

4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

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

6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics.

7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.).

8. Dispensing of drugs not normally utilized in the delivery of dental services.

9. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
   b. is inconsistent with generally accepted standards for dentistry.
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at 800-422-4234.


12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth or the anticipation of future fractures.

14. 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).

15. 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 DeltaCare USA 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.

16. 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.
17. 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 and orthodontic extractions.

18. Treatment or extraction of primary teeth.

19. A Maryland bridge is considered a specialized technique and is not a Benefit. Recementation, repair or replacement of an existing Maryland bridge is not a Benefit.
Accident Injury Benefit

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under Schedule A, Description of Benefits and Copayments.

Delta Dental will pay up to 100 percent of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in Schedule A, Description of Benefits and Copayments.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to Schedule B, Limitations and Exclusions of Benefits, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.
EXCLUSIONS

In addition to Schedule B, limitations #12, #17, and #19 and exclusions #1-9, #11-14 and #17-19, the following exclusions apply:

1. **Prophylaxis.**

2. **Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).**

3. **Replacement of existing restorations due to decay.**

4. **Orthodontic services (treatment of malalignment of teeth and/or jaws).**

5. **Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.**

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.
If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 800-422-4234. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 800-422-4234. También puede recibir este documento en español o chino.

重要通知：您能读懂這封信嗎？如果不能，我們可以請人幫忙。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 1-800-422-4234。