DENTAL BENEFITS ADDENDUM

CENTRAL HEALTH MEDICARE PLAN

Plan F – PPO CAC27

23042

Effective Date: January 1, 2025

Counties:
Alameda, Contra Costa, Fresno, Los Angeles, Orange, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano & Ventura

For Central Health Medicare Plan:

H5649-001, H5649-006, H5649-008, H5649-018, H5649-019, H5649-022, H5649-023

Administered by:

Delta Dental of California

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INTRODUCTION

We are pleased to welcome you to the dental plan for **Central Health Medicare Plan**. Your plan is underwritten and administered by Delta Dental of California ("Delta Dental"). Our goal is to provide you with high 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/her on a regular basis.

Using This Benefits Addendum

This Dental Benefit Addendum ("Plan"), which includes Attachment A, Deductibles and Maximums, Attachment B, Table of Enrollee Copayments & Table of Coinsurances, and Attachment C, Limitations and Exclusions 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 Plan works and how to obtain dental care. Please read this booklet completely and carefully. "We," "us" and "our" always refer to Delta Dental. Please read the Definitions section, which will explain any words that have special or technical meanings in this Plan.

The benefit explanations contained in this Plan booklet are subject to all provisions of the Contract on file with Central Health Medicare Plan ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This Plan booklet is a summary of your dental plan and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered Benefits, services or payments.*

Contact Us

For more information please visit (www.deltadentalins.com/centralhealth) or call Delta Dental's Customer Service Center at (855) 370-3867 (TTY 711). A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Participating Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental's automated information line at (855) 370-3867 during regular business hours to obtain information about Member's eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

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

DEFINITIONS

Terms when capitalized in this Plan booklet have defined meanings, given in the section below or throughout the booklet sections.

Appeal -- is something you do if you disagree with a decision to deny a request for dental care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a service you think you should be able to receive.

Benefits -- the amounts that the Plan will pay for covered dental services.

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

Claim Form -- the standard form used to file a claim or request a Pre-Treatment Estimate.

Contract-- the Agreement between Central Health Medicare Plan and Delta Dental of California for the Provision of Dental Services.

Contractholder -- Central Health Medicare Plan.

Copayment -- the amounts You are responsible for paying as shown in Attachment B.

Cost-sharing -- the amounts which may be charged to Member(s) as the Member's share of the cost for the provision of covered services. Cost sharing consists of coinsurance, copayments, Deductible, and balance billing.

Deductible -- a dollar amount that a Member must pay for certain covered services before the Plan begins paying Benefits.

Delta Dental Participating Medicare Provider (Participating Provider) -- means a person licensed to practice dentistry when and where performed who has entered into a contract with Delta Dental agreeing to participate in this Medicare Advantage Plan and provide covered services to Members.

Delta Dental Participating Medicare Provider Contracted Fee (Participating Provider Contracted Fee) -- the fee for a Single Procedure covered under the Plan that a Participating Provider has contractually agreed to accept as payment in full for covered services.

Effective Date -- the original date the Plan starts. This date is given on this booklet's cover and Attachment A.

Emergency Service -- care furnished to a Member by a Dentist and needed 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 Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Maximum Plan Allowance -- the reimbursement under the Plan against which Delta Dental calculates the Plan's payment and the Member's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Plan Allowance for services provided by a Participating Provider is the lesser of the Provider's Submitted Fee or the Participating Provider Contracted Fee.

Member -- a person with Medicare who is eligible to get covered services, who has enrolled in the Plan and whose enrollment has been confirmed by CMS.

Non-Participating Medicare Provider (Non-Participating Provider) -- a dentist who has not entered into an agreement with Delta Dental to be a Participating Provider under this Medicare Advantage Plan.

Plan -- this dental plan which describes the Benefits, limitations, exclusions, terms and conditions of coverage for Members enrolled in Contractholder's Medicare Advantage Plan.

Plan Benefit Level -- the percentage of the Maximum Plan Allowance that the Plan will pay after the Deductible, if any, has been satisfied as shown in Attachment A.

Plan Year -- the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Plan for the services proposed.

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

Reasonable -- means that a Member 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.

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

Submitted Fee -- the amount that the attending dentist bills and enters on a claim for a specific procedure.

Treatment in Progress -- means any single dental procedure, as defined by the CDT Code that has been started while the Memberwas eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under the 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.

You, Your or Yourself -- the individual receiving dental services.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

The Plan will pay Benefits for the dental services described in Attachment B. The Plan will pay Benefits only for covered services. The Plan covers several categories of dental services when a Participating Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period during which you are a Member of the Plan.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Plan. Even if the dentist bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Loss of Coverage

The Members coverage ends on the last day of the month or immediately when the Contract ends.

Coinsurance

The Plan will pay a percentage of the Maximum Plan Allowance for covered services, as shown in Attachment A and you are responsible for paying the remaining percentage of Maximum Plan Allowance as well as any additional Cost-sharing. The percentage of the Maximum Plan Allowance you are required to pay is called the coinsurance ("Coinsurance"). The Co-insurance is part of your out-of-pocket cost. You pay these even after a Deductible, if any, has been met. In addition to the Coinsurance, and any remaining Deductible, you may be required to pay any amount in excess of your Maximum Amount and the cost of any non-covered services. This is what we mean by Cost-sharing.

The amount of your Coinsurance will depend on the type of service you receive. Participating Providers are required to collect Coinsurance for covered services. Coinsurance is a method of sharing the costs of providing dental Benefits. If the Participating Provider discounts, waives or rebates any portion of the Coinsurance to you, the Plan will be obligated to provide as Benefits only the applicable percentages of the Maximum Plan Allowance reduced by the amount of the fees or allowances that are discounted, waived or rebated.

Maximum Amount

Most dental programs have a maximum amount. A maximum amount ("Maximum Amount" or "Maximum") is the total dollar amount the Plan will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable, if any, is shown in Attachment A. The Maximum Amount may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Participating Provider may file a Claim Form with Delta Dental before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of Benefits payable under the Plan for the listed services. By asking your dentist for a Pre-Treatment Estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Plan terminates;
- the date Benefits under the Plan are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Participating Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the Plan will pay if you are enrolled and meet all the requirements of the Plan program at the time the treatment you have planned is completed. It may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Dentist Within Network

We recognize that many factors affect the choice of dentist and therefore support your right to freely choose your treating dentist within your network. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Participating Provider for your covered treatment. In addition, you can see different Participating Providers within your network.

A Participating Provider is a Delta Dental provider who has agreed to provide covered services under this Medicare Advantage Plan. In order to receive Benefits under this Plan, the dental care you receive must be covered services. The Plan does not pay Benefits for dental care that are not covered services. We highly recommend you verify that the dentist is a Participating Provider in this Medicare Advantage Plan before each appointment to avoid balance billing from Non-Participating Providers. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your Participating Provider selection.

Locating a Delta Dental Participating Provider

There are two ways in which you can locate a Participating Provider near you:

- You may access information through Central Health Medicare Plan website; or
- You may also call Delta Dental's Customer Service Center toll-free at (855) 370-3867 and a representative will assist you. Delta Dental can provide you with information regarding a Delta Dental Participating Provider's specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Participating Provider

Selecting a Participating Provider allows the Member to obtain Benefits for covered services performed for you. Payment to a Participating Provider is calculated based on the Maximum Plan Allowance. Participating Providers agree to accept Delta Dental's Maximum Plan Allowance as payment in full for covered services which means you will only be responsible for any applicable Cost Sharing for the covered service.

The portion of the Maximum Plan Allowance payable by the Plan is limited to the applicable Plan Benefit Level shown in Attachment A. The Plan's payment is sent directly to the Participating Provider who submitted the claim. Delta Dental will advise you of any charges not payable by the Plan for which you are responsible. These Cost Sharing charges are generally your share of the Maximum Plan Allowance (Coinsurance), as well as any Deductibles, charges where the Maximum Amount has been exceeded, and/or charges for non-covered services.

Payment for Services – Non-Participating Provider

The Plan will pay Benefits for covered services provided by a Non-Participating Provider. However, a Non-Participating Provider may charge you more than the Maximum Plan Allowance payable under this Medicare Advantage Plan and you will be responsible for all Cost Sharing charges, and any difference between what Delta Dental pays and the amount the Non-Participating Provider charges up to the Submitted Fee.

Delta Dental contracts with licensed dentists who participate in other dental plans offered by Delta Dental. Not all of these dentists agree or contract with Delta Dental to be a Participating Provider in this Plan. We therefore highly recommend that you verify that the dentist you select is a Participating Provider in this dental Plan before each appointment. The dentist may be under contract for another Delta Dental benefits plan but not necessarily this Plan for Central Health Medicare Plan Health Plan beneficiaries.

How to Submit a Claim

Delta Dental does not require special claim forms. However, most dental offices have Claim Forms available. Participating Providers will fill out and submit your claims paperwork for you. If you wish to submit your own claim directly to Delta Dental, please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

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

CLAIMS APPEAL

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by Delta Dental's telephone representatives. If you have any question or 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 Participating Provider, you have the right to file a grievance or appeal with Central Health Medicare Plan at 866-314-2427.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which dental care is provided, such information and records relating to attendance to or examination of, or treatment provided to you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at the Plan's expense, in or near your community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Form

Delta Dental will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Participating Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by Delta Dental within 15 days after requested by you or your Participating Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Participating Provider may download a Claim Form from Delta Dental's website.

Written Notice of Claim/Proof of Loss

Delta Dental must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within 12 months of the termination of the Plan.

Time of Payment

Claims payable under the Plan for any loss other than loss for which the Plan provides any periodic payment will be processed immediately after written proof of loss is received. Delta Dental will notify you and your Participating Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a Participating Provider will be made directly to the dentist. Any other payments provided by the Plan will be made to you, unless you request when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, or to your estate, or to an alternate recipient as directed by court order, except that if the person is not competent to give a valid release, Benefits may be payable to his or her spouse or guardian or other legally appointed representative.

Legal Actions

No action at law or in equity will be brought to recover under the Plan prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Plan, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Plan.

ATTACHMENT A
Deductibles and Maximums

Contractholder: Central Health Medicare Plan **Group Number:** 23042
Effective Date: January 1, 2025

Deductible and maximum amounts will be determined on a *Calendar Year basis* per Enrollee unless otherwise stated and are subject to **Attachment C - Limitations and Exclusions**.

Dental Service Category	**Delta Dental Participating** **Enrollee Copayments**	**Non-Participating** **Enrollee Coinsurances**
Annual Deductible Per Member	None	
Annual Maximum	$3,000 per Member per Calendar Year ($1,500 of the $3,000 annual calendar year maximum can be used at non-participating Medicare providers)	
Delta Dental will pay or otherwise discharge the Plan Benefit Levels according to the Maximum Plan Allowance for the following services:		

† Reimbursement is based on Delta Dental Participating Medicare Provider Contracted Fees for all providers, including Non-Participating Medicare Providers.

ATTACHMENT B

Please note the following:

- **Delta Dental Participating Provider** When covered services are provided by a Delta Dental Participating Medicare Provider, the Enrollee will pay the copayment amounts listed in column.
- **Non-Participating Provider** - When covered services are provided by a Non-Participating Medicare Provider, the Enrollee will pay thecoinsurance plus the difference between Medicare Participating Provider contracted rate and the dentist's submitted fees.
- All covered services are subject to the limitations and exclusions listed below.

The below codes and nomenclature are copyright of the American Dental Association® ("ADA") and represent the codes and nomenclature excerpted from the 2025 version of Current Dental Terminology ("CDT"). Our administration of benefits, limitations, and exclusions under this plan at all times will be based on the then current version of CDT whether or not a revised table is provided.

Code	Description	Delta Dental Participating Medicare PPO Provider	Non-Participating Providers
D0100-D0999	**I. DIAGNOSTIC**		
- *Two periapical or bitewing x-rays (D0220, D0230, D0270, D0272, D0273, D0274 or D0277) every Calendar Year*			
D0120	Periodic oral evaluation - established patient - *Two oral evaluations (D0120, D0140, D0160 or D0170) every Calendar Year*	No Cost	10%
D0140	Limited oral evaluation - problem focused - *Two oral evaluations (D0120, D0140, D0160 or D0170) every Calendar Year*	No Cost	10%
D0150	Comprehensive oral evaluation - new or established patient - *One comprehensive evaluation (D0150 or D0180) every 3 Calendar Years per provider or location*	No Cost	10%
D0160	Detailed and extensive oral evaluation – problem focused, by report - *Two oral evaluations (D0120, D0140, D0160 or D0170) every Calendar Year*	$17.00	10%
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) - *Two oral evaluations (D0120, D0140, D0160 or D0170) every Calendar Year*	$12.00	10%
D0180	Comprehensive periodontal evaluation - new or established patient - *One comprehensive evaluation (D0150 or D0180) every 3 Calendar Years per provider or location*	No Cost	10%

D0190	Screening of a patient - *One (D0190 OR D0191) every Calendar Year*	No Cost	10%
D0191	Assessment of a patient - *One (D0190 or D0191) every Calendar Year*	No Cost	10%
D0210	Intraoral - comprehensive series of radiographic images - *One (D0210 or D0330) every Calendar Year*	No Cost	10%
D0220	Intraoral - periapical first radiographic image	No Cost	10%
D0230	Intraoral - periapical each additional radiographic image	No Cost	10%
D0240	Intraoral - occlusal radiographic image - *1 per arch per day*	No Cost	10%
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector - *1 per Calendar Year*	No Cost	10%
D0251	Extraoral posterior dental radiographic image - *If there is a history of prior extra-oral radiograph within the frequency limitation for D0330, the fees for D0251 are NOT BILLABLE TO THE PATIENT*	No Cost	10%
D0270	Bitewing - single radiographic image	No Cost	10%
D0272	Bitewings - two radiographic images	No Cost	10%
D0273	Bitewings three radiographic images	No Cost	10%
D0274	Bitewings - four radiographic images	No Cost	10%
D0277	Vertical bitewings - 7 to 8 radiographic images - *One D0277 every Calendar Year*	$41.00	10%
D0330	Panoramic radiographic image - *One (D0210 or D0330) every Calendar Year*	No Cost	10%
D0396	3D printing of a 3D dental surface scan	No Cost	10%
D0419	Assessment of salivary flow by measurement - *1 every 2 Calendar Years*	No Cost	10%
D0460	Pulp vitality tests - *1 every 2 Calendar Years*	$15.00	10%
D0601	Caries risk assessment and documentation, with a finding of low risk - *One (D0601, D0602 or D0603) every 2 Calendar Years*	No Cost	10%
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *One (D0601, D0602 or D0603) every 2 Calendar Years*	No Cost	10%

D0603	Caries risk assessment and documentation, with a finding of high risk - *One (D0601, D0602 or D0603) every 2 Calendar Years*	No Cost	10%
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost	10%
D1000-D1999	**II. PREVENTIVE**		
D1110	Prophylaxis *cleaning* - adult - *Two (D1110, D4346 or D4910) every Calendar Year*	No Cost	10%
D1206	Topical application of fluoride varnish - *Two fluoride applications (D1206 or D1208) every Calendar Year*	$13.00	10%
D1208	Topical application of fluoride - excluding varnish - *Two fluoride applications (D1206 or D1208) every Calendar Year*	No Cost	10%
D1310	Nutritional counseling for control of dental disease - *One every Calendar Year*	No Cost	10%
D1320	Tobacco counseling for the control and prevention of oral disease - *Two every Calendar Year*	No Cost	10%
D1330	Oral hygiene instructions - *One every Calendar Year*	No Cost	10%
D2000-D2999	**III. RESTORATIVE**		
- The removal of an indirect restoration is a part of a subsequent restorative procedure.			
- 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 old.			
- Two fillings procedures every Calendar Year (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394)			
- Two crown or onlay procedures every Calendar Year (any combination of D2542 - D2544, D2642 - D2644, D2710 - D2794, D2931)			
D2140	Amalgam - one surface, primary or permanent	No Cost	70%
D2150	Amalgam - two surfaces, primary or permanent	No Cost	70%
D2160	Amalgam - three surfaces, primary or permanent	No Cost	70%
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost	70%
D2330	Resin-based composite - one surface, anterior	No Cost	70%
D2331	Resin-based composite - two surfaces, anterior	No Cost	70%
D2332	Resin-based composite - three surfaces, anterior	No Cost	70%
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost	70%

D2390	Resin-based composite crown, anterior	$111.00	70%
D2391	Resin-based composite - one surface, posterior	$46.00	70%
D2392	Resin-based composite - two surfaces, posterior	$64.00	70%
D2393	Resin-based composite - three surfaces, posterior	$77.00	70%
D2394	Resin-based composite - four or more surfaces, posterior	$85.00	70%
D2542	Onlay - metallic - two surfaces - *One crown or onlay per tooth every 5 Calendar Years*	$382.00	70%
D2543	Onlay - metallic - three surfaces -*One crown or onlay per tooth every 5 Calendar Years*	$384.00	70%
D2544	Onlay - metallic - four or more surfaces -*One crown or onlay per tooth every 5 Calendar Years*	$385.00	70%
D2642	Onlay - porcelain/ceramic - two surfaces - *One crown or onlay per tooth every 5 Calendar Years*	$421.00	70%
D2643	Onlay - porcelain/ceramic - three surfaces - *One crown or onlay per tooth every 5 Calendar Years*	$423.00	70%
D2644	Onlay - porcelain/ceramic - four or more surfaces - - *One crown or onlay per tooth every 5 Calendar Years*	$424.00	70%
D2710	Crown - resin-based composite (indirect) - *One crown or onlay per tooth every 5 Calendar Years*	$150.00	70%
D2712	Crown - 3/4 resin-based composite (indirect) - *One crown or onlay per tooth every 5 Calendar Years*	$149.00	70%
D2720	Crown - resin with high noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$220.00	70%
D2721	Crown - resin with predominantly base metal - *One crown or onlay per tooth every 5 Calendar Years*	No Cost	70%
D2722	Crown - resin with noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$180.00	70%
D2740	Crown - porcelain/ceramic - *One crown or onlay per tooth every 5 Calendar Years*	$220.00	70%
D2750	Crown - porcelain fused to high noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$295.00	70%
D2751	Crown - porcelain fused to predominantly base metal - *One crown or onlay per tooth every 5 Calendar Years*	$75.00	70%
D2752	Crown - porcelain fused to noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$255.00	70%

D2753	Crown - porcelain fused to titanium and titanium alloys - *One crown or onlay per tooth every 5 Calendar Years*	$295.00	70%
D2780	Crown - 3/4 cast high noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$220.00	70%
D2781	Crown - 3/4 cast predominantly base metal - *One crown or onlay per tooth every 5 Calendar Years*	$180.00	70%
D2782	Crown - 3/4 cast noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$180.00	70%
D2783	Crown - 3/4 porcelain/ceramic - *One crown or onlay per tooth every 5 Calendar Years*	$180.00	70%
D2790	Crown - full cast high noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$220.00	70%
D2791	Crown - full cast predominantly base metal - *One crown or onlay per tooth every 5 Calendar Years*	No Cost	70%
D2792	Crown - full cast noble metal - *One crown or onlay per tooth every 5 Calendar Years*	$220.00	70%
D2794	Crown - titanium and titanium alloys - *One crown or onlay per tooth every 5 Calendar Years*	No Cost	70%
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core - *One recement (D2915 or D2920) per tooth every 2 Calendar Years*	$31.00	70%
D2920	Re-cement or re-bond crown - *One recement (D2915 or D2920) per tooth every 2 Calendar Years*	No Cost	70%
D2921	Reattachment of tooth fragment, incisal edge or cusp - *One per tooth every 2 Calendar Years*	No Cost	70%
D2928	Prefabricated porcelain/ceramic crown - permanent tooth - *One per tooth every 2 Calendar Years*	$221.00	70%
D2931	Prefabricated stainless steel crown - permanent tooth - *One crown or onlay per tooth every 5 Calendar Years*	No Cost	70%
D2940	Placement of interim direct restoration- *One per tooth per lifetime*	No Cost	70%
D2949	Restorative foundation for an indirect restoration	No Cost	70%
D2950	Core buildup, including any pins when required - *One (D2950, D2952 or D2954) per tooth every 5 Calendar Years*	No Cost	70%
D2951	Pin retention - per tooth, in addition to restoration - *One per tooth every 2 Calendar Years*	No Cost	70%

D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation - One (D2950, D2952 or D2954) per tooth every 5 Calendar Years*	$100.00	70%
D2953	Each additional indirectly fabricated post - same tooth - - *includes canal preparation - One per tooth every 5 Calendar Year when billed with D2952*	$75.00	70%
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation - One (D2950, D2952 or D2954) per tooth every 5 Calendar Years*	No Cost	70%
D2956	Removal of an indirect restoration on a natural tooth	No Cost	70%
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost	70%
D2980	Crown repair necessitated by restorative material failure - *One per tooth every 2 Calendar Years*	$23.00	70%
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost	70%
D3000-D3999	**IV. ENDODONTICS**		
- *Two root canal procedures every Calendar Year (D3310, D3320, D3330, D3346, D3347 or D3348)*			
D3110	Pulp cap - direct (excluding final restoration)	No Cost	70%
D3120	Pulp cap - indirect (excluding final restoration)	No Cost	70%
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	No Cost	70%
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	No Cost	70%
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	No Cost	70%
D3331	Treatment of root canal obstruction; non-surgical access	No Cost	70%
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	No Cost	70%
D3346	Retreatment of previous root canal therapy - anterior	No Cost	70%
D3347	Retreatment of previous root canal therapy - premolar	No Cost	70%
D3348	Retreatment of previous root canal therapy - molar	No Cost	70%
D3410	Apicoectomy - anterior - *One per tooth per lifetime*	No Cost	70%
D3421	Apicoectomy - premolar (first root) - *One per tooth per lifetime*	No Cost	70%

D3425	Apicoectomy - molar (first root) - *One per tooth per lifetime*	No Cost	70%
D3426	Apicoectomy (each additional root) - *One per tooth per lifetime*	No Cost	70%
D4000-D4999	**V. PERIODONTICS**		
- *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*			
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *One (D4341 or D4342) per quadrant every 2 Calendar Years*	No Cost	70%
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *One (D4341 or D4342) per quadrant every 2 Calendar Years*	No Cost	70%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *Two (D1110, D4346 or D4910) every Calendar Year*	No Cost	10%
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on subsequent visit - *One per tooth every 2 Calendar Years*	No Cost	70%
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *One per tooth every 2 Calendar Years*	No Cost	70%
D4910	Periodontal maintenance - *Two (D1110, D4346 or D4910) every Calendar Year*	No Cost	70%
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost	70%
D5000-D5899	**VI. PROSTHODONTICS (removable)**		
- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*			
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*			
D5110	Complete denture - maxillary - *One maxillary denture (D5110 or D5130) every 5 Calendar Years*	No Cost	70%
D5120	Complete denture - mandibular - *One mandibular denture (D5120 or D5140) every 5 Calendar Years*	No Cost	70%

D5130	Immediate denture - maxillary - *One maxillary denture (D5110 or D5130) every 5 Calendar Years*	No Cost	70%
D5140	Immediate denture - mandibular - *One mandibular denture (D5120 or D5140) every 5 Calendar Years*	No Cost	70%
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) - *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	No Cost	70%
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) - *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	No Cost	70%
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	No Cost	70%
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	No Cost	70%
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) - *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	No Cost	70%
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) - *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	No Cost	70%
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	No Cost	70%
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	No Cost	70%

D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	$220.00	70%
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	$220.00	70%
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) *One partial maxillary denture (D5211, D5213, D5221, D5223, D5225 or D5227) every 5 Calendar Years*	No Cost	70%
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) *One partial mandibular denture (D5212, D5214, D5222, D5224, D5226 or D5228) every 5 Calendar Years*	No Cost	70%
D5410	Adjust complete denture - maxillary - *Two every Calendar Years*	No Cost	70%
D5411	Adjust complete denture - mandibular - *Two every Calendar Years*	No Cost	70%
D5421	Adjust partial denture - maxillary - *Two every Calendar Years*	No Cost	70%
D5422	Adjust partial denture - mandibular - *Two every Calendar Years*	No Cost	70%
D5511	Repair broken complete denture base, mandibular - *One every Calendar Year*	No Cost	70%
D5512	Repair broken complete denture base, maxillary - *One every Calendar Year*	No Cost	70%
D5520	Replace missing or broken teeth - complete denture (per tooth) - *One every Calendar Year*	No Cost	70%
D5611	Repair resin partial denture base, mandibular - *One (D5611 or D5621) every Calendar Year*	No Cost	70%
D5612	Repair resin partial denture base, maxillary - *One (D5612 or D5622) every Calendar Year*	No Cost	70%
D5621	Repair cast partial framework, mandibular - *One (D5611 or D5621) every Calendar Year*	$95.00	70%
D5622	Repair cast partial framework, maxillary - *One (D5612 or D5622) every Calendar Year*	$90.00	70%

D5630	Repair or replace broken retentive/clasping materials - per tooth - *One (D5611 - D5660) every Calendar Year*	$77.00	70%
D5640	Replace missing or broken teeth – partial denture - per tooth - *One (D5611 - D5660) every Calendar Year*	No Cost	70%
D5650	Add tooth to existing partial denture - per tooth - *One (D5611 - D5660) every Calendar Year*	No Cost	70%
D5650	Add tooth to existing partial denture - *One (D5611 - D5660) every Calendar Year*	No Cost	70%
D5660	Add clasp to existing partial denture - per tooth - *One (D5611 - D5660) every Calendar Year*	No Cost	70%
D5710	Rebase complete maxillary denture - *One every 2 Calendar Years*	$50.00	70%
D5711	Rebase complete mandibular denture - *One every 2 Calendar Years*	$50.00	70%
D5720	Rebase maxillary partial denture - *One every 2 Calendar Years*	$50.00	70%
D5721	Rebase mandibular partial denture - *One every 2 Calendar Years*	$50.00	70%
D5725	Rebase hybrid prosthesis - *One every 2 Calendar Years*	$50.00	70%
D5730	Reline complete maxillary denture (chairside) - *Two (D5730, D5740, D5750, D5760 or D5765) per Calendar Year*	No Cost	70%
D5731	Reline complete mandibular denture (chairside) - *Two (D5731, D5741, D5751, D5761 or D5765) per Calendar Year*	No Cost	70%
D5740	Reline maxillary partial denture (chairside) - *Two (D5730, D5740, D5750, D5760 or D5765) per Calendar Year*	No Cost	70%
D5741	Reline mandibular partial denture (chairside) - *Two (D5731, D5741, D5751, D5761 or D5765) per Calendar Year*	No Cost	70%
D5750	Reline complete maxillary denture (laboratory) - *Two (D5730, D5740, D5750, D5760 or D5765) per Calendar Year*	No Cost	70%
D5751	Reline complete mandibular denture (laboratory) - *Two (D5731, D5741, D5751, D5761 or D5765) per Calendar Year*	No Cost	70%

D5760	Reline maxillary partial denture (laboratory) - *Two (D5730, D5740, D5750, D5760 or D5765) per Calendar Year*	$50.00	70%
D5761	Reline mandibular partial denture (laboratory) - *Two (D5731, D5741, D5751, D5761 or D5765) per Calendar Year*	$50.00	70%
D5765	Soft liner for complete or partial removable denture - indirect - *Two (D5730, D5731, D5740 D5741, D5750, D5751, D5760, D5761 or D5765) per Calendar Year*	$50.00	70%
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *One every 5 Calendar Years*	$170.00	70%
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *One every 5 Calendar Years*	$170.00	70%
D5850	Tissue conditioning, maxillary - *One every Calendar Year*	No Cost	70%
D5851	Tissue conditioning, mandibular - *One every Calendar Year*	No Cost	70%
D5900-D5999	**VII. MAXILLOFACIAL PROSTHETICS - Not Covered**		
D6000-D6199	**VIII. IMPLANT SERVICES**		
- One surgical implant placement (D6010, D6013 or D6040) per implant site every 5 Calendar Years			
- Two implant-supported prosthetics (D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082 or D6094) every Calendar Year			
- One implant-supported prosthetic (D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082 or D6094) per implant site every 5 Calendar Years			
D6010	Surgical placement of implant body: endosteal implant - *Two (D6010 or D6013) every Calendar Year*	$1,023.00	70%
D6011	Surgical access to an implant body (second stage implant surgery)	$247.00	70%
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant - *Two every Calendar Year*	$726.00	70%
D6013	Surgical placement of mini implant - *Two (D6010 or D6013) every Calendar Year*	$665.00	70%

D6040	Surgical placement: eposteal implant - *One every Calendar Year*	$2,160.00	70%
D6050	Surgical placement: transosteal implant - *One every Calendar Year*	$2,051.00	70%
D6055	Connecting bar - implant supported or abutment supported - *One every Calendar Year - One per arch every 5 Calendar Years*	$1,231.00	70%
D6056	Prefabricated abutment - includes modification and placement - *Two (D6056, D6057) every calendar One per implant site every 5 Calendar Years*	$418.00	70%
D6057	Custom fabricated abutment - includes placement - *Two (D6056, D6057) every calendar - One per implant site every 5 Calendar Years*	$486.00	70%
D6058	Abutment supported porcelain/ceramic crown	$502.00	70%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$456.00	70%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$435.00	70%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$448.00	70%
D6062	Abutment supported cast metal crown (high noble metal)	$453.00	70%
D6063	Abutment supported cast metal crown (predominantly base metal)	$433.00	70%
D6064	Abutment supported cast metal crown (noble metal)	$445.00	70%
D6065	Implant supported porcelain/ceramic crown	$567.00	70%
D6066	Implant supported crown – porcelain fused to high noble alloys	$565.00	70%
D6067	Implant supported crown - high noble alloys	$562.00	70%
D6068	Abutment supported retainer for porcelain/ceramic FPD	$595.00	70%
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$626.00	70%
D6070	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$404.00	70%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$540.00	70%

D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$527.00	70%
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$495.00	70%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$517.00	70%
D6075	Implant supported retainer for ceramic FPD	$515.00	70%
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$738.00	70%
D6077	Implant supported retainer for metal FPD - high noble alloys	$548.00	70%
D6080	Implant maintenance procedures when a full arch fixed hybrid prostheses is removed and reinserted, including cleansing of prostheses and abutments - *One every Calendar Year - One per arch every 3 Calendar Years*	$96.00	70%
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, or bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure - *One every Calendar Year - One per implant site every 2 Calendar Years*	$103.00	70%
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$431.00	70%
D6089	Accessing and retorquing loose implant screw - per screw - *limited to once per 24 months*	$86.00	70%
D6090	Repair of implant/abutment supported prosthesis - *One every Calendar Year - One per implant site every 5 Calendar Years*	$127.00	70%
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment - *One every Calendar Year One per implant site every 5 Calendar Years*	$136.00	70%
D6096	Remove broken implant retaining screw - *One per tooth every 5 Calendar Years*	$86.00	70%
D6100	Surgical removal of implant body - *One every Calendar Year - One per implant site every 5 Calendar Years*	$192.00	70%

D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure - *One every Calendar Year - One per implant every 3 Calendar Years*	$263.00	70%
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure - *One every Calendar Year One per implant every 3 Calendar Years*	$447.00	70%
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure - *One every Calendar Year One per implant every 3 Calendar Years*	$263.00	70%
D6104	Bone graft at time of implant placement -*One every Calendar Year*	$270.00	70%
D6105	Removal of implant body not requiring bone removal or flap elevation - *One every Calendar Year One per implant site every 5 Calendar Years*	No Cost	70%
D6190	Radiographic/surgical implant index, by report - *One per arch every 5 Calendar Years*	$174.00	70%
D6198	Remove interim implant component - *Included in fee for prosthetic service*	No Cost	70%
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 old*			
- *One pontic (D6240, D6241, D6242, or D6243) per tooth per 5 Calendar Years*			
- *One retainer crown (D6750, D6751, D6752 or D6753) per tooth per 5 Calendar Years*			
D6240	Pontic - porcelain fused to high noble metal	$295.00	70%
D6241	Pontic - porcelain fused to predominantly base metal	$75.00	70%
D6242	Pontic - porcelain fused to noble metal	$255.00	70%
D6243	Pontic - porcelain fused to titanium and titanium alloys	$255.00	70%
D6750	Retainer crown - porcelain fused to high noble metal	$295.00	70%
D6751	Retainer crown - porcelain fused to predominantly base metal	$75.00	70%
D6752	Retainer crown - porcelain fused to noble metal	$255.00	70%

D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$295.00	70%
D7000-D7999	**X. ORAL AND MAXILLOFACIAL SURGERY**		
- ***Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.***			
- ***Three extractions every Calendar Year (D7140, D7210, D7220, D7230, D7240, D7241, D7250 or D7251)***			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) - *One extraction per tooth per lifetime*	No Cost	70%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated - *One extraction per tooth per lifetime*	No Cost	70%
D7220	Removal of impacted tooth - soft tissue - *1 extraction per tooth per lifetime*	No Cost	70%
D7230	Removal of impacted tooth - partially bony - *1 extraction per tooth per lifetime*	No Cost	70%
D7240	Removal of impacted tooth - completely bony - *1 extraction per tooth per lifetime*	No Cost	70%
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications - *1 extraction per tooth per lifetime*	No Cost	70%
D7250	Removal of residual tooth roots (cutting procedure) - *1 extraction per tooth per lifetime*	No Cost	70%
D7251	Coronectomy - intentional partial tooth removal- *One extraction per tooth per lifetime*	$237.00	70%
D7252	Partial extraction for immediate implant placement – *Once in a lifetime*	No Cost	70%
D7259	Nerve dissection – only covered when done in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications	No Cost	70%
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant- *One (D7310 or D7311) per quadrant per lifetime*	No Cost	70%
D7311	Alveoloplasty in conjunction with extractions - *One (D7310 or D7311) per quadrant per lifetime*	No Cost	70%

D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant - *One (D7320 or D7321) per quadrant per lifetime*	No Cost	70%
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant - *One (D7320 or D7321) per quadrant per lifetime*	No Cost	70%
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site- *Included in fee for completed service*	No Cost	70%
D8000-D8999	**XI ORTHODONTICS - Not Covered**		
D9000-D9999	**XI IADJUNCTIVE GENERAL SERVICES**		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia - *Included in fee for completed service*	No Cost	70%
D9310	Consultation - diagnostic service provided by a dentist or physician other than requesting dentist or physician - *One per lifetime per provider*	No Cost	10%
D9311	Consultation with a medical health care professional - *included in fee for other services*	No Cost	70%
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed - *Not separately payable*	$28.00	10%
D9440	Office visit - after regularly scheduled hours - *One every Calendar Year*	$58.00	10%
D9450	Case presentation, subsequent to detailed and extensive treatment planning	$93.00	10%
D9912	Pre-visit patient screening- *Included in fee for completed service*	No Cost	10%
D9932	Cleaning and inspection of removable complete denture, maxillary - *Not separately payable*	No Cost	10%
D9933	Cleaning and inspection of removable complete denture, mandibular - *Not separately payable*	No Cost	10%
D9934	Cleaning and inspection of removable partial denture, maxillary - *Not separately payable*	No Cost	10%
D9935	Cleaning and inspection of removable partial denture, mandibular - *Not separately payable*	No Cost	10%
D9951	Occlusal adjustment - limited - for natural teeth only - *One every 5 Calendar Years*	$38.00	70%

D9952	Occlusal adjustment - complete - for permanent dentition- *One every 5 Calendar Years*	$166.00	70%
D9990	Certified translation or sign-language services - per visit - *Included in fee*	No Cost	10%
D9991	Dental case management - addressing appointment compliance barriers- *Included in fee*	No Cost	10%
D9992	Dental case management - care coordination - *included in fee*	No Cost	10%
D9995	Teledentistry - synchronous; real-time encounter - *Not separately payable. Included in fee for other services*	No Cost	10%
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review - *Not separately payable. Included in fee for other services*	No Cost	10%
D9997	Dental case management - Patients with special Health Care Needs - *Not separately payable. Included in fee for other services*	No Cost	10%

* *In Network Enrollee Copay is the amount the patient pays for the listed procedure. Copayments apply to PPO providers.*

** *Out of Network Maximum Allowance is the maximum amount Delta Dental will pay toward the listed procedure.*

NOTE: *The procedures described and copayments and maximum allowances indicated on this table are subject to the terms of the contract and Delta Dental standard processing policies. Any procedure not listed on this schedule is not covered. The In-Network copays are subject to change each year. This plan may be updated to be CDT compliant.*

ATTACHMENT C

LIMITATIONSServices that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

a. a composite restoration instead of an amalgam restoration on posterior teeth with the exception of facial surfaces on pre-molar teeth;
b. a crown where a filling would restore the tooth;
c. an onlay instead of an amalgam restoration;
d. porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
e. an overdenture instead of denture.

If an Enrollee receives Optional Services, an Alternate Benefit will be allowed, which means the Plan will pay Benefits on the lower cost of the alternate service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the alternate service or standard procedure.

2) Exam and cleaning limitations:
   a. Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) no more than twice in a Calendar Year.
   b. Delta Dental will pay for one (1) comprehensive oral evaluation or comprehensive periodontal evaluation per provider or location every three (3) Calendar Years.
   c. Delta Dental will pay for prophylaxis (routine cleanings), periodontal maintenance cleanings, scaling in the presence of inflammation, or any combination thereof twice in a Calendar Year
   d. A full mouth debridement is allowed once every two (2) Calendar Years
   e. Periodontal maintenance cleanings and full mouth debridement are covered as a Major Benefit, and prophylaxis (routine cleanings) are covered as a Diagnostic and Preventive Benefit.

3) X-ray limitations:
   a. Delta Dental will limit the total reimbursable amount to the Dentist's Submitted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Submitted Fee for a comprehensive intraoral series.
   b. Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every two (2) Calendar Years.
   c. If a panoramic image is taken in conjunction with a comprehensive intraoral series, Delta Dental will limit reimbursement to the Dentist's Submitted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the enrollee's responsibility. Panoramic images are not considered part of a comprehensive intraoral series.

d. An enrollee may have either two (2) periapical images or one (1) set of bitewing images in a Calendar Year. Bitewings of any type are disallowed within 6 months of a full mouth series unless warranted by special circumstances.
e. Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.

4) Topical application of fluoride solutions is limited to twice in a Calendar Year.

5) Pulp vitality tests are allowed once every two (2) Calendar Years when definitive treatment is not performed.

6) Specialist Consultations are limited to once per lifetime per Provider. Screenings of patients and assessments of patients are limited to once per Calendar Year.

7) Neither Delta Dental nor the enrollee is responsible for the replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within two (2) Calendar Years of treatment if the service is provided by the same Provider/Provider office.

8) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

9) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime per tooth. Retreatment of root canal therapy by the same Provider/Provider office two (2) Calendar Years is considered part of the original procedure.

10) Root canal therapy/retreatments are limited to no more than two (2) in a Calendar Year

11) Retreatment of apical surgery by the same Provider/Provider office within 2 Calendar Years is considered part of the original procedure.

12) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

13) Periodontal limitations:
a. Benefits for periodontal scaling and root planing in the same quadrant are limited to once every two (2) Calendar Years.
b. Periodontal surgery in the same quadrant is limited to once in every three (3) Calendar Years and includes any surgical re-entry or scaling and root planing.
c. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
d. Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.

e. Cleanings (prophylaxis and periodontal maintenance) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

14) Oral Surgery services that are covered under the dental plan are covered once per tooth/quadrant/arch in a lifetime. The exception to this is the removal of cysts and lesions, and incision and drainage procedures, which are covered once in the same day.

15) Extractions are limited to no more than three (3) in a Calendar Year.

16) Crowns and onlays are covered once per tooth in a five (5) Calendar Year period, except when Delta Dental determines the existing Crown or Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

17) Crowns and onlays are limited to no more than two (2) in a Calendar Year.

18) Core buildup, including any pins, are covered once per tooth in a five (5) Calendar Year period.

19) Post and core services are covered once per tooth in a five (5) Calendar Year period.

20) Crown repairs are covered once per tooth every two (2) Calendar Year period, and are not covered within two (2) Calendar Years of initial placement.

21) Denture repairs are covered once per arch every Calendar Year, and not covered within six (6) months of initial placement.

22) Implants that were provided under any Delta Dental program will be replaced only after five (5) Calendar Years have passed. Prosthodontic appliances or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after five (5) Calendar Years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.

23) Implants and implant supported prosthetics are limited to no more than two (2) in a Calendar Year.

24) The fee for accessing and retorquing a loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis.Repairs to implant/abutment supported prosthesis (crowns, bridges and dentures), are part of the prosthetic procedure, when done within 6 months of the initial prosthesis, by the same dentist/dental office.

26) The Socket Shield technique, partial extraction of the root of a tooth at the time of implant placement, is only a benefit when done with simultaneous implant placement.
27) Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.

28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

29) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation one per tooth every two (2) Calendar Years.

30) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. Payment includes routine post delivery care, including any adjustments and relines for the first six (6) months after placement.
    a. Denture rebase is limited to one (1) per arch in a 2 Calendar Year period and includes any relining and adjustments for six (6) months following placement.
    b. Dentures, removable partial dentures and relines include adjustments for six (6) months following insertion. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to two (2) per arch in a Calendar Year.
    c. Immediate dentures and immediate removable partial dentures include reline and adjustments for three (3) months following insertion. After the initial (3) months of adjustments or relines, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to two (2) per arch in a Calendar Year.
    d. Tissue conditioning is limited to one (1) per arch in a Calendar Year. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
    e. Recementation of fixed partial dentures is limited to once every two (2) Calendar Years.

31) When done in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications, nerve dissection is part of that extraction procedure. Otherwise, nerve dissection is not a benefit.

EXCLUSIONS

Delta Dental does not pay Benefits for:

1) services not included in **Attachment B -** Dental Procedure Codes and Descriptions.

2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

3) cosmetic surgery or procedures for purely cosmetic reasons.

4) maxillofacial prosthetics.

5) provisional and/or temporary restorations. Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, abrasion, or abfraction or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards.

8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

10) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

11) extra oral grafting, (the use of autogenous grafts taken from other, non oral, parts of the body of the enrollee). This language is not meant to exclude non-autogenous grafts obtained from tissue banks or other manufacturers.

12) interim implants and endodontic endosseous implants.

13) indirectly fabricated resin-based Inlays/Onlays.

14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling.

17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract is not a covered Benefit. Any tax will be the responsibility of the Enrollee.

20) deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

21) services covered under the dental plan, which exceed Benefit limitations, or are not in accordance with processing policies in effect at the time the claim is processed.

22) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws).

23) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues).

24) services or supplies for sealants, space maintainers, services to aid the exposure or eruption of an unerupted or impacted tooth, use of temporary anchorage devices, and transseptal/fiberotomy/supra crestal fiberotomy.

25) missed and/or cancelled appointments.

26) services or supplies for nitrous oxide.

27) antigen or antibody testing.

28) counseling for the control and prevention of adverse oral, behavioral, and systematic health effects associated with high-risk substance use.

29) Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

30) The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

31) Dental case management motivational interviewing and patient education to improve oral health literacy.

32) Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

33) Extra-oral - 2D projection radiographic image and extra-oral posterior dental radiographic image.

34) Diabetes testing.

35) Corticotomy (specialized oral surgery procedure associated with orthodontics).

36) The fee for teledentistry services are considered inclusive in overall patient management and are not a separately payable service.