



FHFA Dental Insurance Program



Dental program guide 2023



feds.deltadentalins.com/fhfa

Delta Dental is a registered trademark of Delta Dental Plans Association.

Table of contents

Introduction	1
Program overview	2
Plan summary	2
Eligibility	3
Manage your account – Website registration	3
Employees	3
Enrollment	3
Premiums	3
Survivor benefits	3
Termination of coverage	3
Retirees	4
Dentist networks	4
PPO networks (Delta Dental PPO™ and Delta Dental Premier®)	4
PPO	5
Summary of PPO benefits	5
Covered services	6
Alternate benefit	16
Limitations	16
Exclusions (Non-covered services)	25
Claims	27
In-network claims	28
Out-of-network claims	28
Pre-treatment estimates	28
Coordination of Benefits (COB)	29
Appeals	29
Grievances	30

HIPAA Notice of Privacy Practices	31
Confidentiality of your health information	31
Permitted uses and disclosures of your PHI	31
Your Rights Regarding PHI	32
Complaints	34
Contacts	34
Language assistance	34
Delta Dental and its affiliates	35
Wellness efforts	35
Delta Dental contact information	35
Glossary	36



Introduction

Effective January 1, 2023, Delta Dental of California’s Federal Government Programs division began administering dental benefits under the Federal Housing Finance Agency Dental Insurance Program for active and retired employees of the FHFA and their eligible family members.

Eligibility to participate. Active employees may enroll in the dental insurance program with the option to continue enrollment in retirement. Participation in dental coverage must be initiated by employees through the completion and submission of a dental insurance election form. Enrollment may be initiated by the employee at any time during the plan year. Eligible dependents are the employee’s spouse or domestic partner; up to age 26 the following: unmarried dependent children, children legally adopted, stepchildren and foster children who depend on the employee for support and maintenance; and eligible dependents over age 26 if disabled prior to their 26th birthday. Please contact FHFA Human Resources if you have any questions regarding eligibility for family members.

The FHFA Dental Insurance Program will provide you with:

- Quality, cost-effective dental coverage
- A nationwide network of contracted dentists for both options
- Confidence that your dental health is a priority

Delta Dental has designed a website specifically for the FHFA Dental Insurance Program to help with your program needs. At feds.deltadentalins.com/fhfa, you can search for a network dentist, find program materials, and view frequently asked questions (FAQ), as well as register to use the member portal. Through the portal, you can access your personal information, print your ID card, view the status of your claims, print copies of your explanation of benefits (EOB) statements, and much more.

Call Delta Dental’s Customer Service department at **888-497-0675** for questions you may have regarding your benefits, eligibility or claims. Your dentist can also contact the Delta Dental Customer Service department at this toll-free number if he or she has questions regarding your eligibility or claims. If you require assistance in an alternative language, please advise the Delta Dental Customer Service representative; this service is provided at no charge.

Important information regarding the FHFA Dental Insurance Program:

Website	feds.deltadentalins.com/fhfa
Group name	Federal Housing Finance Agency (FHFA)
Customer Service	Toll-free phone number: 888-497-0675. If you are deaf, hard of hearing or have a speech disability, please dial 711 to access telecommunications relay services. Representatives are available between 8 am and 8 pm. (Eastern time), Monday through Friday (excluding holidays).
24-Hour dental benefits automated number for dentists	844-825-8111 (used by dentists to obtain a detailed fax of the dental benefits coverage)
Payer ID	CDCA1 (used by dentists when filing claims electronically)

Program overview

The FHFA Dental Insurance Program is a preferred provider organization (PPO). With Delta Dental as the program's administrator, the plan is known as the Delta Dental PPO™ plan.

Plan summary

The chart below provides an overview of your plan. Please note that all out-of-network services under the PPO plan are paid based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using an out-of-network dentist.

Benefits and covered services	In-network Delta Dental PPO dentist	Out-of-network ¹ Non-participating dentist
Diagnostic & preventive services: Oral examinations, routine cleanings, x-rays, fluoride treatments, sealants	100%	100%
Basic services: Fillings, space maintainers, crown repair, inlays, onlays and dentures	95% ²	80% ²
Major services: Crowns, inlays, onlays and cast restorations	90% ²	60% ²
Endodontics: Root canals	90% ²	50% ²
Periodontics: Gum treatment	90% ²	60% ²
Oral surgery: Incisions, excisions, simple and surgical extractions	90% ²	50% ²
Prosthodontics: Bridges, dentures, implants, adjustments to dentures and partials	80% ²	50% ²
Benefits for diabetic and pregnant patients: One additional periodontal maintenance per year Select periodontal surgical procedures	100%	100%
Orthodontic benefit Eligible employees and their dependents	75%	50%
Orthodontic lifetime maximum	\$5,000	\$2,000
Annual deductible Deductible waived for diagnostic & preventive and orthodontic procedures	\$50/individual \$150/family	\$100/individual \$300/family
Annual maximum per insured person	Unlimited	Unlimited

If you choose an out-of-network dentist, you may pay more than the applicable copayment of your plan, and out-of-network benefits will apply. Deductibles and maximums may apply for services provided by an out-of-network dentist.

1 Non-Delta Dental, non-contracted dentists (out-of-network dentists) are paid based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using a non-network dentist.

2 Subject to the annual deductible.

Eligibility

Active employees may enroll in the dental insurance program, with the option to continue enrollment in retirement.

An employee can cover their spouse or domestic partner, unmarried children up to age 26 (which includes foster children, legally adopted children and stepchildren who depend on the employee for support and maintenance), as well as eligible dependents over age 26 if disabled prior to their 26th birth date.

Manage your account - website registration

Once you have enrolled in the program, you are encouraged to use the Member Portal located at feds.deltadentalins.com/fhfa, to verify your enrollment and gain access to benefit and claims information.

To register, follow these steps:

1. Go to feds.deltadentalins.com/fhfa.
2. Click on the **Sign up!** link on the left-hand side of the page. Then enter your:
 1. First name
 2. Last name (including suffix)
 3. Date of birth
 4. Member ID (your SSN or Alt ID)
 5. Member type (select subscriber)
3. After you have successfully established your username and password, retain them in a safe place for future reference.

Employees

As an eligible employee, you have various opportunities to enroll in the program and to make changes.

Enrollment

Active employees may enroll in the dental insurance program, with the option to continue enrollment in retirement. Participation in dental coverage must be initiated by employees through the completion and submission of a dental insurance election form. Enrollment may be initiated by the employee at any time during the plan year.

Once an employee has enrolled in the program, Delta Dental will send the new enrollee a welcome packet.

Employees will receive a notification sent to their workplace email that contains links to Delta Dental's website for the program and to the member portal, which allows you to print an ID card and access other program information. Note that ID cards are not necessary to obtain benefits; however, you can print an ID card that will display your name.

When a family member is no longer an eligible dependent (e.g., due to divorce, legal separation, death of a dependent, marriage of a dependent child, etc.) or you simply wish to remove a dependent from coverage, you must notify FHFA Human Resources by completing and submitting the Dental Enrollment Form indicating your desire to remove the dependent

as an eligible dependent. The enrollment change will become effective at the end of the month in which FHFA Human Resources receives the enrollment form.

Premiums

FHFA pays 100% of the premium for employees and eligible dependents.

Survivor benefits

In the event of the death of an active employee, continued eligibility to participate in the program will be extended to the deceased employee's dependents who are currently enrolled at the time of the active employee's death. FHFA Human Resources will notify the deceased employee's dependents of continuation of coverage based on the survivor benefits provision under the program.

Termination of coverage

Coverage for employees will terminate either on the last day of the month the employee separates from the agency, the last day of the month the employee elects to voluntarily cancel their participation in the program, or the day the group policy terminates, whichever happens first.

Retirees

If employees decide to continue coverage into retirement, they must complete the enrollment process 31 days prior and up to 60 days after retirement from the agency. Enrolled retirees receive pricing based on the agency's negotiated rates. In the event the agency terminates the contract with the vendor, the retiree is eligible to maintain coverage as an individual participant at the agency's final premium rate.

FHFA Retirees - Monthly Premium Rates Effective January 1, 2023	
Single (retiree only)	\$37.76
Two people (retiree and one dependent)	\$75.44
Family (retiree and two or more dependents)	\$140.93

Dentist network

Delta Dental offers two participating dentist networks. The participating networks available to enrollees are the Delta Dental PPO™ network and the Delta Dental Premier® network. A list of dentists participating in these Delta Dental networks is available at feds.deltadentalins.com/fhfa.

PPO networks (Delta Dental PPO and Delta Dental Premier)

The PPO plan allows you to visit any licensed dentist of your choice for treatment. Although the PPO plan provides for both in-network and out-of-network benefits, you will receive the greatest benefit when you visit a participating dentist in the Delta Dental PPO network. Dentists who participate in the Delta Dental PPO network have agreed to reduced, contracted rates. Moderate savings is achieved when you visit a dentist who participates in the Delta

Dental Premier network. The Delta Dental Premier network provides cost protections for PPO enrollees. Their fees are typically higher than the fees of a PPO dentist, but because the fees of a Premier dentist are capped, you can save on out-of-pocket costs. Neither PPO nor Premier dentists will “balance bill” you for additional fees, unbundle services or require pre-payment for services. You are only responsible for any applicable deductibles, coinsurance, charges for non-covered services and amounts over plan maximums.

For services provided by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks, Delta Dental will reimburse the dentist according to a negotiated rate. For services provided by an out-of-network dentist, Delta Dental will pay based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using a non-network dentist.

PPO plan

The PPO plan provides both in-network and out-of-network benefits. Under this plan, you are required to pay coinsurance for services rendered by your dentist. Reimbursement levels for treatment provided by an in-network dentist are based on contracted fees. Reimbursement levels for treatment provided by an out-of-network dentist are paid based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using a non-network dentist. Your benefits under the plan are limited to an orthodontia lifetime maximum. You are also required to meet an annual deductible for certain services. For a family enrollment, each person, up to three people, must satisfy the individual annual deductible. Below is a summary of the benefits under the PPO plan.

Summary of benefits

Benefits and covered services	In-network Delta Dental PPO dentist	Out-of-network ¹ Non-participating dentist
Diagnostic & preventive services: Oral examinations, routine cleanings, x-rays, fluoride treatments, sealants	100%	100%
Basic services: Fillings, space maintainers, crown repair, inlays, onlays and dentures	95% ²	80% ²
Major services: Crowns, inlays, onlays and cast restorations	90% ²	60% ²
Endodontics: Root canals	90% ²	50% ²
Periodontics: Gum treatment	90% ²	60% ²
Oral surgery: Incisions, excisions, simple and surgical extractions	90% ²	50% ²
Prosthodontics: Bridges, dentures, implants, adjustments to dentures and partials	80% ²	50% ²
Benefits for diabetic and pregnant patients: One additional periodontal maintenance per year Select periodontal surgical procedures	100%	100%

Benefits and covered services	In-network Delta Dental PPO dentist	Out-of-network ¹ Non-participating dentist
Orthodontic benefit Eligible employees and their dependents	75%	50%
Orthodontic lifetime maximum	\$5,000	\$2,000
Annual deductible Deductible waived for diagnostic & preventive and orthodontic procedures	\$50/individual \$150/family	\$100/individual \$300/family
Annual maximum per insured person	Unlimited	Unlimited

1 Non-Delta Dental, non-contracted dentists (out-of-network dentists) are paid based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using a non-network dentist.

2 Subject to the annual deductible.

Covered services

Procedures that are covered under the FHFA Dental Insurance Program’s PPO plan are listed in this section and are identified by the code and description as recognized by the American Dental Association (ADA). Some services that are not covered under the program are listed as exclusions. Refer to the Limitations and Exclusions sections of this guide for further details.

Certain PPO benefits are subject to time limitations that specify how often the benefit can be paid. Time limitations pertain to the period of time immediately preceding the date of the service being billed. Time limitations can vary depending on the procedure. For more detailed information regarding time limitations, refer to the Limitations section of this guide.

Covered services for the program are determined by generally accepted dental practice standards. All covered services listed in this section conform to the 2023 version of the ADA Current Dental Terminology (CDT). Below is a list of all of the covered services under the FHFA Dental Insurance Program’s PPO plan.

Diagnostic services

- D0120 Periodic oral evaluation – established patient
- D0140 Limited oral evaluation – problem-focused
- D0145 Oral evaluation for patient under three years of age and counseling with primary caregiver
- D0150 Comprehensive oral evaluation – new or established patient
- D0180 Comprehensive periodontal evaluation – new or established patient
- D0210 Intraoral – complete series of radiographic images
- D0220 Intraoral – periapical first radiographic image
- D0230 Intraoral – periapical each additional radiographic image
- D0240 Intraoral – occlusal radiographic image
- D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector
- D0251 Extra-oral posterior dental radiographic image
- D0270 Bitewing – single radiographic image

- D0272 Bitewings – two radiographic images
- D0273 Bitewings – three radiographic images
- D0274 Bitewings – four radiographic images
- D0277 Vertical bitewings – seven to eight radiographic images
- D0330 Panoramic radiographic image
- D0425 Caries susceptibility tests
- D0701 Panoramic radiographic image - image capture only
- D0705 Extra-oral posterior dental radiographic image - image capture only
- D0706 Intraoral - occlusal radiographic image - image capture only
- D0707 Intraoral - periapical radiographic image - image capture only
- D0708 Intraoral - bitewing radiographic image - image capture only
- D0709 Intraoral - comprehensive series of radiographic images - image capture only

Preventive services

- D1110 Prophylaxis – adult
- D1120 Prophylaxis – child through age 13
- D1206 Topical application of fluoride varnish
- D1208 Topical application of fluoride – excluding varnish
- D1351 Sealant – per tooth
- D1510 Space maintainer - fixed, unilateral - per quadrant
- D1516 Space maintainer – fixed – bilateral, maxillary
- D1517 Space maintainer – fixed – bilateral, mandibular
- D1520 Space maintainer - removable, unilateral - per quadrant
- D1526 Space maintainer – removable – bilateral, maxillary
- D1527 Space maintainer – removable – bilateral, mandibular
- D1551 Re-cement or re-bond bilateral space maintainer – maxillary
- D1552 Re-cement or re-bond bilateral space maintainer – mandibular
- D1553 Re-cement or re-bond unilateral space maintainer – per quadrant
- D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant
- D4910 Periodontal maintenance

Adjunctive general services

- D9110 Palliative treatment of dental pain – per visit

Basic restorative services

- D2140 Amalgam – one surface, primary or permanent
- D2150 Amalgam – two surfaces, primary or permanent
- D2160 Amalgam – three surfaces, primary or permanent
- D2161 Amalgam – four or more surfaces, primary or permanent
- D2330 Resin-based composite – one surface, anterior
- D2331 Resin-based composite – two surfaces, anterior
- D2332 Resin-based composite – three surfaces, anterior

D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	Re-cement or re-bond crown
D2930	Prefabricated stainless steel crown – primary tooth
D2931	Prefabricated stainless steel crown – permanent tooth
D2951	Pin retention – per tooth, in addition to restoration

Endodontic services

D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junctions and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D3310	Endodontic therapy, anterior tooth (excluding final restoration)
D3320	Endodontic therapy, premolar tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (excluding final restoration)
D3346	Retreatment of previous root canal therapy – anterior
D3347	Retreatment of previous root canal therapy – premolar
D3348	Retreatment of previous root canal therapy – molar
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification – interim medication replacement
D3353	Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy – anterior
D3421	Apicoectomy – premolar (first root)
D3425	Apicoectomy – molar (first root)
D3426	Apicoectomy – (each additional root)
D3430	Retrograde filling – per root
D3450	Root amputation – per root
D3471	Surgical repair of root resorption – anterior
D3472	Surgical repair of root resorption – premolar

- D3473 Surgical repair of root resorption – molar
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
- D3921 Decoronation or submergence of an erupted tooth

Periodontic services

- D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces per quadrant
- D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
- D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
- D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
- D4241 Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
- D4249 Clinical crown lengthening – hard tissue
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
- D4263 Bone replacement graft – first site in quadrant
- D4264 Bone replacement graft – each additional site in quadrant
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site
- D4266 Guided tissue regeneration, natural teeth – resorbable barrier, per site
- D4268 Surgical revision procedure, per tooth
- D4270 Pedicle soft tissue graft procedure
- D4273 Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
- D4276 Combined connective tissue and pedicle graft
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4341 Periodontal scaling and root planing – four or more teeth per quadrant

- D4342 Periodontal scaling and root planing – one to three teeth per quadrant
- D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on subsequent visit
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

Prosthodontic services - removable

- D5410 Adjust complete denture – maxillary
- D5411 Adjust complete denture – mandibular
- D5421 Adjust partial denture – maxillary
- D5422 Adjust partial denture – mandibular
- D5511 Repair broken complete denture base, mandibular
- D5512 Repair broken complete denture base, maxillary
- D5520 Replace missing or broken teeth – complete denture (each tooth)
- D5611 Repair resin partial denture base, mandibular
- D5612 Repair resin partial denture base, maxillary
- D5621 Repair cast partial framework, mandibular
- D5622 Repair cast partial framework, maxillary
- D5630 Repair or replace broken retentive clasping materials – per tooth
- D5640 Replace broken teeth – per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture – per tooth
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary) – per tooth
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular)

Prosthodontic services - fixed

- D6980 Fixed partial denture repair necessitated by restorative material failure, by report

Oral surgery services

- D7111 Extraction, coronal remnants – primary tooth
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
- D7220 Removal of impacted tooth – soft tissue
- D7230 Removal of impacted tooth – partially bony
- D7240 Removal of impacted tooth – completely bony
- D7241 Removal of impacted tooth – completely bony, with unusual surgical complications
- D7250 Removal residual tooth roots (cutting procedure)
- D7251 Coronoectomy – intentional partial tooth removal, impacted teeth only
- D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
- D7280 Exposure an unerupted tooth
- D7283 Placement of device to facilitate eruption of impacted tooth
- D7286 Incisional biopsy of oral tissue – soft

- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7510 Incision and drainage of abscess - intraoral soft tissue
- D7910 Suture of recent small wounds up to 5 cm
- D7921 Collection and application of autologous blood concentrate product
- D7953 Bone replacement graft for ridge preservation - per site
- D7961 Buccal/labial frenectomy (frenulectomy)
- D7962 Lingual frenectomy (frenulectomy)
- D7971 Excision of pericoronal gingiva
- D7999 Unspecified oral surgery procedure, by report

Adjunctive general services

- D9222 Deep sedation/general anesthesia - first 15 minutes
- D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment
- D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes
- D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment

Diagnostic services

- D0160 Detailed and extensive oral evaluation - problem focused, by report

Major restorative services

- D2510 Inlay - metallic - one surface
- D2520 Inlay - metallic - two surfaces
- D2530 Inlay - metallic - three or more surfaces
- D2542 Onlay - metallic - two surfaces
- D2543 Onlay - metallic - three surfaces
- D2544 Onlay - metallic - four or more surfaces
- D2610 Inlay - porcelain/ceramic - one surface
- D2620 Inlay - porcelain/ceramic - two surfaces
- D2630 Inlay - porcelain/ceramic - three or more surfaces
- D2644 Onlay - porcelain/ceramic - four or more surfaces
- D2740 Crown - porcelain/ceramic
- D2750 Crown - porcelain fused to high noble metal
- D2751 Crown - porcelain fused to predominantly base metal
- D2752 Crown - porcelain fused to noble metal
- D2753 Crown - porcelain fused to titanium or titanium alloy
- D2780 Crown - $\frac{3}{4}$ cast high noble metal

- D2781 Crown - ¾ cast predominantly base metal
- D2782 Crown - ¾ cast noble metal
- D2783 Crown - ¾ porcelain/ceramic
- D2790 Crown - full cast high noble metal
- D2791 Crown - full cast predominantly base metal
- D2792 Crown - full cast noble metal
- D2794 Crown - titanium/titanium alloy
- D2950 Core buildup, including any pins when required
- D2954 Prefabricated post and core in addition to crown
- D2962 Labial veneer (porcelain laminate) - laboratory
- D2980 Crown repair necessitated by restorative material failure, by report
- D2981 Inlay repair necessitated by restorative material failure
- D2982 Onlay repair necessitated by restorative material failure
- D2983 Veneer repair necessitated by restorative material failure
- D2990 Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15

Implants

- D6010 Surgical placement of implant body: endosteal implant
- D6055 Connecting bar - implant supported or abutment supported
- D6056 Prefabricated abutment - includes modification and placement
- D6057 Custom fabricated abutment - includes placement
- D6058 Abutment supported porcelain/ceramic crown
- D6059 Abutment supported porcelain fused to metal crown (high noble metal)
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
- D6061 Abutment supported porcelain fused to metal crown (noble metal)
- D6062 Abutment supported cast metal crown (high noble metal)
- D6063 Abutment supported cast metal crown (predominantly base metal)
- D6064 Abutment supported cast metal crown (noble metal)
- D6065 Implant supported porcelain/ceramic crown
- D6066 Implant supported porcelain fused to metal crown (high noble alloys)
- D6067 Implant supported metal crown (high noble alloys)
- D6068 Abutment supported retainer for porcelain/ceramic FPD
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- D6072 Abutment supported retainer for cast metal FPD (high noble metal)
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
- D6074 Abutment supported retainer for cast metal FPD (noble metal)
- D6075 Implant supported retainer for ceramic FPD
- D6076 Implant supported retainer for porcelain fused to metal FPD (high noble alloys)
- D6077 Implant supported retainer for metal FPD (high noble alloys)

- D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
- D6082 Implant supported crown – porcelain fused to predominantly base alloys
- D6083 Implant supported crown – porcelain fused to noble alloys
- D6084 Implant supported crown – porcelain fused to titanium or titanium alloy
- D6086 Implant supported crown – predominantly base alloys
- D6087 Implant supported crown – noble alloys
- D6088 Implant supported crown – titanium/titanium alloys
- D6090 Repair implant supported prosthesis, by report
- D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
- D6094 Abutment supported crown titanium or titanium alloys
- D6095 Repair implant abutment, by report
- D6096 Remove broken implant retaining screw
- D6097 Abutment supported crown – porcelain fused to titanium or titanium alloys
- D6098 Implant supported retainer for metal FPD – porcelain fused to predominantly base alloys
- D6099 Implant supported retainer for metal FPD – porcelain fused to noble alloys
- D6100 Surgical removal of implant body
- D6105 Removal of implant body not requiring bone removal nor flap elevation
- D6110 Implant/abutment supported removable denture for edentulous arch – maxillary
- D6111 Implant/abutment supported removable denture for edentulous arch – mandibular
- D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary
- D6113 Implant/abutment supported removable denture for partially edentulous arch – mandibular
- D6114 Implant/abutment supported fixed denture for edentulous arch – maxillary
- D6115 Implant/abutment supported fixed denture for edentulous arch – mandibular
- D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary
- D6117 Implant/abutment supported fixed denture for partially edentulous arch – mandibular
- D6120 Implant supported retainer – porcelain fused to titanium or titanium alloy
- D6121 Implant supported retainer for metal FPD – predominantly base alloys
- D6122 Implant supported retainer for metal FPD – noble alloys
- D6123 Implant supported retainer for metal FPD – titanium or titanium alloy
- D6194 Abutment supported retainer crown for FPD metal titanium or titanium alloys
- D6195 Abutment supported retainer – porcelain fused to titanium or titanium alloy
- D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant

Prosthetic services - removable

- D5110 Complete denture – maxillary
- D5120 Complete denture – mandibular

- D5130 Immediate denture - maxillary
- D5140 Immediate denture - mandibular
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)
- D5221 Immediate maxillary partial denture - resin base (including any retentive/ clasping materials, rests and teeth)
- D5222 Immediate mandibular partial denture - resin base (including any retentive/ clasping materials, rests and teeth)
- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)
- D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)
- D5282 Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), maxillary
- D5283 Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), mandibular
- D5286 Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant
- D5710 Rebase complete maxillary denture
- D5711 Rebase complete mandibular denture
- D5720 Rebase maxillary partial denture
- D5721 Rebase mandibular partial denture
- D5725 Rebase hybrid prosthesis
- D5730 Reline complete maxillary denture (chairside)
- D5731 Reline complete mandibular denture (chairside)
- D5740 Reline maxillary partial denture (chairside)
- D5741 Reline mandibular partial denture (chairside)
- D5750 Reline complete maxillary denture (laboratory)
- D5751 Reline complete mandibular denture (laboratory)
- D5760 Reline maxillary partial denture (laboratory)
- D5761 Reline mandibular partial denture (laboratory)
- D5765 Soft liner for complete or partial removable denture - indirect
- D5850 Tissue conditioning, maxillary
- D5851 Tissue conditioning, mandibular

Prosthodontic services - fixed

- D6210 Pontic - cast high noble metal
- D6211 Pontic - cast predominantly base metal
- D6212 Pontic - cast noble metal
- D6214 Pontic - titanium or titanium alloys
- D6240 Pontic - porcelain fused to high noble metal

D6241	Pontic - porcelain fused to predominantly base metal
D6242	Pontic - porcelain fused to noble metal
D6243	Pontic - porcelain fused to titanium or titanium alloys
D6245	Pontic - porcelain/ceramic substrate
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6600	Retainer inlay - porcelain/ceramic, two surfaces
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces
D6604	Retainer inlay - cast predominantly base metal, two surfaces
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces
D6608	Retainer onlay - porcelain/ceramic, two surfaces
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces
D6612	Retainer onlay - cast predominantly base metal, two surfaces
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces
D6740	Retainer crown - porcelain/ceramic
D6750	Retainer crown - porcelain fused to high noble metal
D6751	Retainer crown - porcelain fused to predominantly base metal
D6753	Retainer crown - porcelain fused to titanium or titanium alloys
D6752	Retainer crown - porcelain fused to noble metal
D6780	Retainer crown - $\frac{3}{4}$ cast high noble metal
D6781	Retainer crown - $\frac{3}{4}$ cast predominantly base metal
D6782	Retainer crown - $\frac{3}{4}$ cast noble metal
D6783	Retainer crown - $\frac{3}{4}$ porcelain/ceramic
D6784	Retainer crown - $\frac{3}{4}$ titanium and titanium alloys
D6790	Retainer crown - full cast high noble metal
D6791	Retainer crown - full cast predominantly base metal
D6792	Retainer crown - full cast noble metal
D6794	Retainer crown - titanium or titanium alloys
D6930	Re-cement or re-bond fixed partial denture

Adjunctive general services

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral drug, single administration
D9612	Therapeutic parenteral drugs, two or more administrations, different medications
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report
D9941	Fabrication of athletic mouthguard
D9944	Occlusal guard - hard appliance, full arch
D9945	Occlusal guard - soft appliance, full arch
D9946	Occlusal guard - hard appliance, partial arch
D9974	Internal bleaching - per tooth
D9999	Unspecified adjunctive procedure, by report

Orthodontic services

D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Alternate benefit

When more than one dental service could provide suitable treatment based on common dental standards, an alternate benefit may be determined by Delta Dental. If Delta Dental applies an alternate benefit to a covered service submitted on a claim, the patient's Explanation of Benefits statement will indicate the following:

- The procedure code of the alternate benefit that was applied when the claim was processed
- An explanation as to why the alternate benefit was applied
- The patient's cost responsibility based on the fee for the alternate benefit

Limitations

Policy limitations for diagnostic services (Class I services)

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a calendar year. A comprehensive periodontal evaluation will be considered integral if provided on the same date of service by the same dentist as any other oral evaluation.
2. Only one comprehensive evaluation (D0150) will be allowed in a calendar year.
3. Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-month period. A limited oral evaluation will be considered integral when provided on the same date of service by the same dentist as any other oral evaluation.
4. Re-evaluations are considered integral to the originally performed procedures.
5. A full-mouth series (complete series) of radiographic images includes bitewings. Any additional radiographic image taken with a complete radiographic image series is considered integral to the complete series.
6. A panoramic radiographic image taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.
7. If the individually listed radiographs equals or exceeds a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.

8. Payment for more than one of any category of full-mouth radiographic images within a 48-month period is the patient's responsibility. If a full-mouth series (complete series) is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional radiographic images.
9. Payment for panoramic radiographic images is limited to one within a 48-month period.
10. Payment for periapical radiographic images (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.
11. Payment for a bitewing survey, whether single, two, three, four or vertical radiographic image(s), including those taken as part of a complete series, is limited to one within a 12-month period.
12. Radiographic images of non-diagnostic quality are not payable.
13. Test reports must describe the pathological condition, type of study and rationale.

Policy limitations for preventive services

1. Two routine prophylaxes are covered in a calendar year.
2. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance procedures.
3. Routine prophylaxes are considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planning, periodontal maintenance, gingivectomies or gingivoplasties, gingival flap procedures, mucogingival surgery, or osseous surgery.
4. Routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.
5. Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and paid as such. Participating dentists may not bill the patient for any difference in fees.
6. FHFA's dental plan covers two topical fluoride applications in a calendar year period for all enrollees (any age).
7. Space maintainers are only covered for dependent children under the age of 19.
8. Sealants are covered on permanent molars for children up to age 19. The teeth must be caries free with no previous restorations on the mesial, distal or occlusal surfaces. One sealant per tooth is covered in a three-year period.
9. Sealants for teeth other than permanent molars are not covered.
10. Sealants provided on the same date of service and on the same tooth as a restorations of the occlusal surface are considered integral procedures.

Policy limitations for adjunctive general services

1. For palliative (emergency) treatment to be covered, it must involve a problem or symptom that occurred suddenly and unexpectedly and that requires immediate attention.

2. In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the patient's problem. If the only service provided is to evaluate the patient and refer to another dentists and/or prescribe medication, the service would be considered a limited oral evaluation – problem-focused.

Policy limitations for basic restorative services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951) in addition to a crown is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentists. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restorations involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.
7. Restorations are not covered when performed after the placement of any type of crown or inlay/onlay, on the same tooth and by the same dentist.
8. The payment for restorations includes all related services to include, but not limited to, etching, bases, liners, dental adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
9. Prefabricated stainless steel crowns (D2930, D2931) are covered only on primary teeth, permanent teeth through age 14, or when placed as a result of accidental injury. They are limited to one per tooth, per lifetime.
10. Recementation of prefabricated crowns is eligible once per six-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.

Policy limitations for endodontic services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for patients up to age six and for primary molars and cuspids to age 11 and is limited to once per tooth per lifetime. Payment for the pulpal therapy will be offset by the allowance for a pulpotomy provided within 45 days preceding pulpal therapy on the same tooth by the same dentist.

4. Treatment of a root canal obstruction is considered an integral procedure.
5. Incomplete endodontic therapy is not a covered benefit when due to the patient discontinuing treatment.
6. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
7. Placement of a final restoration following endodontic therapy is eligible as a separate procedure.

Policy limitations for periodontal services

1. Gingivectomy or gingivoplasty, gingival flap procedure, guided tissue regeneration, soft tissue grafts, bone replacement grafts and osseous surgery provided within 36 months of the same surgical periodontal procedure in the same area of the mouth are not covered.
2. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered integral to the restoration.
3. Surgical periodontal procedures in the same area of the mouth within 36 months of a gingival flap procedure are not covered.
4. Gingival flap procedure is considered integral when provided on the same date of service by the same dentist in the same area of the mouth as periodontal surgical procedures, endodontic procedures and oral surgery procedures.
5. Subepithelial connective tissue grafts and combined connective tissue and double pedicle grafts are payable at the level of free soft tissue grafts. The difference between the allowance for the soft tissue graft and the dentist's charge is the patient's responsibility.
6. A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g., crater) or surfaces involved. Another site on the same tooth is considered integral to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.
7. Osseous surgery is not covered when provided within 36 months of osseous surgery in the same area of the mouth.
8. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service by the same dentist and in the same area of the mouth will be processed as crown lengthening.
9. Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or interbony defects. It is not covered when provided to obtain root coverage or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g., apicoectomy or hemisection.
10. One crown lengthening per tooth per lifetime is covered.
11. Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing or periodontal surgical procedures in the same area of the mouth are not covered.

12. A routine prophylaxis is considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure or osseous surgery.
13. Up to four periodontal maintenance procedures and up to two routine prophylaxes may be paid within calendar year, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a 12-month period.
14. Periodontal maintenance is only covered when performed following active periodontal treatment.
15. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policy and limitations applicable to oral evaluations.
16. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure.
17. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.
18. Full mouth debridement to enable comprehensive evaluation and diagnosis (D4355) is covered once per lifetime.
19. Bone grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.
20. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.
21. Up to two tissue grafts are payable per quadrant per visit. Additional tissue grafts performed in a quadrant are not covered benefits.
22. Localized delivery of antimicrobial agents via a controlled release vehicle is not a covered benefit when provided in conjunction with scaling and root planing.

Policy limitations for oral surgery services

1. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
2. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.
3. Charges for related services such as necessary wires and splints, adjustments, and follow-up visits are considered integral to the fee for reimplantation and/or stabilization.
4. Routine postoperative care such as suture removal is considered integral to the fee for the surgery.

5. The removal of impacted teeth is paid based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, payment will be based on the allowance for the lesser level.
6. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal.
7. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.
8. The fee for frenulectomy is included when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist.

Policy limitations for adjunctive general services

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered surgical procedure(s) and when rendered by a dentist or other professional provider licensed and approved to provide anesthesia in the state where the service is rendered.
2. Deep sedation/general anesthesia and intravenous conscious sedation are covered only by report when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
3. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted and approved.
4. Deep sedation/general anesthesia and intravenous conscious sedation submitted without a report will be denied as a non-covered benefit.

Policy limitations for diagnostic services

1. Detailed and extensive oral evaluations (D0160) are limited to once per patient per dental office.

Policy limitations for major restorative services

1. The charge for a crown or inlay/onlay should include all charges for work related to its placement to include, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.
2. Inlays, onlays, permanent single crown restorations, and posts and cores for patients 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.).
3. Core buildups (D2950) can be considered for benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.

4. Cast posts and cores (D2952) are processed as an alternative benefit of a prefabricated post and core. The patient is responsible for the difference between the dentist's charge for the cast post and core and the amount paid for the prefabricated post and core.
5. Recementation of cast crowns, bridges, onlays/inlays and posts is eligible once per six-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
6. Replacement of crowns, inlays, onlays, buildups, and posts and cores is covered only if the existing crown, inlay, onlay, buildup or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, inlay, onlay, buildup or post and core is not and cannot be made serviceable. The five-year service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.
7. Inlays, onlays, crowns, and posts and cores are payable only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, payment will be made for that service. This payment can be applied toward the cost of the inlay, onlay, crown, or post and core.
8. Crowns, inlays, onlays, buildups, or posts and cores begun prior to the effective date of coverage or cemented after the cancellation date of coverage are not eligible for payment.
9. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown or implant and are considered integral to the buildup or implant.
10. Payment for a resin restoration will be made when a laboratory-fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.

Policy limitations for implant services

1. Implant services are not eligible for patients under 14 unless submitted with x-rays and approved by Delta Dental.
2. Implants may not be covered when placed for a removable denture.
3. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.
4. Replacement of an implant prosthesis is covered only if the existing prosthesis was placed at least five years prior to the replacement and satisfactory evidence presented that demonstrates that it is not, and cannot be made, serviceable.
5. Repair of an implant-supported prosthesis (D6090), repair of an implant abutment (D6095), and removal of broken implant retaining screw (D6096) are only payable by report upon Delta Dental dentist advisor review and is only payable once in five years. The report should describe the problem and how it was repaired.

Policy limitations for prosthodontic services

1. For reporting and benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the provider who fabricated the dentures may be reimbursed for the dentures after insertion if another provider, typically an oral surgeon, inserted the dentures.
2. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures are included in the fee for these procedures. A separate fee is not chargeable to the member by a participating dentist.
3. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.
4. Recementation of cast crowns, fixed partial dentures, inlays, onlays, or cast posts within six months of their placement by the same dentist is considered integral to the original procedure.
5. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are integral to the denture or implant.
6. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.
7. A reline/rebase is covered once in any 36 months.
8. Fixed partial dentures, buildups, and posts and cores for members under 16 years of age are not covered unless specific rationale is provided indicating the necessity for such treatment.
9. Payment for a denture or an overdenture made with precious metals is based on the allowance for a conventional denture. Specialized procedures performed in conjunction with an overdenture are not covered. Any additional cost is the patient's responsibility.
10. A fixed partial denture and removable partial denture are not covered benefits in the same arch. Payment will be made for a removable partial denture to replace all missing teeth in the arch.
11. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
12. Temporary fixed partial dentures are not a covered benefits and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.
13. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three-unit fixed partial denture.
14. Replacement of removable prostheses and fixed prostheses is covered only if the existing removable and/or fixed prostheses were inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing removable and/or fixed prostheses cannot be made serviceable. The five-year service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.
15. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.

16. Removable or fixed prostheses initial prior to the effective date of coverage or inserted/cemented after the cancellation date of coverage are not eligible for payment.

Policy limitations for adjunctive general services

1. Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.
2. Consultations reported for a non-covered benefit, such as temporomandibular joint dysfunction (TMJD), are not covered.
3. After-hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the patient in an emergency situation.
4. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.
5. Occlusal guards are covered for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Limited to one every 5 years and for patients 13 years of age and older.
6. Athletic mouth guards are limited to one per 12-consecutive-month period.
7. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative x-rays is required for consideration if the endodontic therapy has not been submitted to the Contractor for payment.
8. Internal bleaching of discolored teeth (D9974) is eligible once per tooth per three-year period.

Policy limitations for orthodontics

1. Initial payment for orthodontic services will not be made until a banding date has been submitted.
2. All retention and case-finishing procedures are integral to the total case fee.
3. Observations and adjustments are integral to the payment for retention appliances. Repair of damaged orthodontic appliances is not covered.
4. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is integral to the orthodontic appliance. However, recementation by a different dentist will be considered for payment as palliative treatment.
5. The replacement of a lost or missing appliance is not a covered benefit.
6. Myofunctional therapy is integral to orthodontic treatment and not payable as a separate benefit.
7. Periodic orthodontic treatment visits are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate services. Delta Dental uses this code when making periodic payments as part of the complete treatment plan payment.
8. It is the dentist's and the patient's responsibility to promptly notify Delta Dental if orthodontic treatment is discontinued or completed sooner than anticipated.
9. Post-operative orthodontic records including radiographs, models and records taken during treatment are included in the fee for the orthodontic treatment.

10. When a patient transfers to a different orthodontic dentist, payment and any additional records, etc. will be subject to review and recalculation of benefits.
11. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

Exclusions (non-covered services)

Except as specifically provided, the following services, supplies or charges are not covered:

1. Any dental service or treatment not specifically listed as a covered service.
2. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the Contractor will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
3. Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse. This includes spouse, siblings, parents, children, grandparents and the spouse's siblings and parents.
4. Those submitted by a dentist which are for the same services performed on the same date for the same patient by another dentist.
5. Those which are experimental or investigative (deemed unproven).
6. Those which are for any illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the patient claims the benefits or compensation.
7. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
8. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
9. Those for which the patient would have no obligation to pay in the absence of this or any similar coverage.
10. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
11. Those performed prior to the patient's effective coverage date.
12. Those incurred after the termination date of the patient's coverage unless otherwise indicated.
13. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.)
14. Those not meeting accepted standards of dental practice.
15. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.

16. Those performed by a dentist who is compensated by a facility for similar covered services performed for patients.
17. Those resulting from the patient's failure to comply with professionally prescribed treatment.
18. Telephone consultations.
19. Any charges for failure to keep a scheduled appointment.
20. Duplicate and temporary devices, appliances, and services.
21. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
22. Plaque control programs, oral hygiene instruction, and dietary instructions.
23. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.
24. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restorations for misalignment of teeth.
25. Gold foil restorations.
26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
27. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
28. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
29. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
30. Office infection control charges.
31. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
32. Adjunctive dental services as defined by applicable federal regulations.
33. Charges for copies of patients' records, charts or x-rays, or any costs associated with forwarding/ mailing copies of patients' records, charts or x-rays.
34. Duplication of radiographic images for administrative purposes is not payable.
35. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.
36. Nitrous oxide.
37. Oral sedation.
38. State or territorial taxes on dental services performed.
39. Any self-administered (mail order or do-it yourself) type of orthodontics are not covered.
40. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.

Claims

Dentists can call Delta Dental's toll-free 24-hour automated line at 844-825-8111 to obtain a fax of your covered benefits. The FHFA Dental Insurance Program does not require the use of a special claim form. Network dentists will complete and submit claims for you. Some out-of-network dentists may also provide this service upon your request (sometimes at a fee); however, they are not required to file claims on your behalf. A claim form can be obtained at feds.deltadentalins.com/fhfa.

For Delta Dental to process your claim quickly, it is important that the claim form is filled out completely and correctly. If you are completing your own claim form and do not have access to the necessary information, contact your dentist for assistance. The following information is required for each claim:

- Patient's name and birth date
- Subscriber's name, mailing address and birth date
- Subscriber's identification number (social security number or alternate ID)
- Phone number and/or email
- Group/Policy Number: Federal Housing Finance Agency
- Dentist name and license number
- Dentist's treatment office address, city, state and ZIP code
- Date the service was completed
- Description of the service provided
- Appropriate CDT procedure code that corresponds to the service provided
- Fee charged
- Tooth number/letter and surface/arch, where appropriate

Claims can be submitted

By fax: 916-851-1559

Electronically: Dentists should use Payer ID "CDCA1" when submitting claims electronically

By mail: Delta Dental of California
Federal Government Programs
P.O. Box 537007
Sacramento, CA 95853-7007

Claims must be received by Delta Dental within 12 months of the date of service in order to be processed. Claims received on or after the first day of the month following the 12-month claims filing deadline will be denied by Delta Dental. Network dentists cannot charge you for Delta Dental's portion of the fee for services that Delta Dental denies because the claim was submitted after the deadline.

In-network claims

Your network dentist will file claims for you. Delta Dental will remit benefit payment directly to your network dentist.

Out-of-network claims

If you receive treatment from an out-of-network dentist, you may be required to pay the dentist up front, and you may also have to file your own claim for reimbursement of the treatment provided. When you file a claim for reimbursement of treatment provided by an out-of-network dentist, Delta Dental will remit benefit payment directly to you unless you have signed the *Assignment of benefits* section of the claim form authorizing direct payment to the dentist.

Treatment received from a dentist overseas is considered to be performed by an out-of-network dentist. To be reimbursed for treatment received overseas, you must complete, sign and submit a claim form to Delta Dental, along with the detailed original receipt obtained from the dentist. If you reside outside the continental U.S., you may use Delta Dental's secure online Customer Service Inquiry Form to submit your claims for payment. Delta Dental will convert the fees to U.S. dollars and make payment directly to the enrollee in U.S. dollars based on the date of service.

Pre-treatment estimates

Requests for pre-treatment estimates are not required but are recommended. For major procedures, you are strongly encouraged to submit a pre-treatment estimate to eliminate any surprises regarding covered benefits. The pre-treatment estimate outlines the dentist's proposed treatment plan on a claim form and should include specific procedure code(s) and x-rays, if needed. Dates of service are left blank because the treatment is only proposed and not yet completed. Upon request for a pre-treatment estimate, Delta Dental will provide the dentist with a non-binding, written estimate of how much the Delta Dental PPO Plan will cover for a particular service under the program. A copy of the pre-treatment estimate will be sent to the dentist and patient.

When the treatment has been completed, the dentist will fill in the date(s) of service, sign and date the form, and return the Pre-treatment Estimate notice to Delta Dental.

Coordination of benefits (COB)

Dental carriers coordinate benefits when other coverage is noted on the claim, allowing patients to maximize their coverage under both programs. It is both your responsibility and to your advantage to let your dentist and Delta Dental know if you have other dental coverage in addition to your PPO coverage under the FHFA Dental Insurance Program.

Under this program, benefits are coordinated by first calculating the plan benefits that would normally be paid, then reducing this amount by the payment made by the primary plan. Be sure to request that your dentist complete the "Other coverage" portion of the claim form to ensure that all benefits are coordinated appropriately.

Coordination of benefits (COB) takes place when a patient is entitled to benefits from more than one dental plan. The plans will coordinate benefits to eliminate duplication of benefit payments. If you have other dental insurance, please share the following information with your dentist so he or she submits your claim appropriately. The provisions for COB under the FHFA Dental Plan are as follows:

- If you are the primary enrollee in the FHFA Dental Insurance Program but are not the primary enrollee in a Federal Employees Health Benefits (FEHB) plan or Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, then your coverage under the FHFA Dental Insurance Program is primary.

- If you are the primary enrollee in the FHFA Dental Insurance Program and are also the primary enrollee in a Federal Employees Health Benefits (FEHB) plan or Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, then your coverage under the FHFA Dental Insurance Program is secondary to any coverage under your federal employee dental plans.
- If you have dental coverage under another dental plan (except for FEHB and FEDVIP dental coverage) then the FHFA Dental Insurance Program will pay as primary, unless the other dental plan is considered primary then FHFA will pay as secondary.
- If your child is covered as a dependent under your dental plan and your spouse's dental plan, the "birthday rule" will apply. This rule, defined by the National Association of Insurance Commissioners, is based on the plan whose primary enrollee's month and day of birth is earlier in the year. (The birth year of either parent is not considered under the birthday rule.)

Appeals

Delta Dental will notify you on your Explanation of Benefits (EOB) if any claims for dental services are denied, in whole or in part, stating the specific reason(s) for denial. If you believe there is an error in processing your claim, please call Delta Dental's Customer Service department. If there was an error, in most cases Delta Dental can reprocess the denial of your claim based on your phone call. If you still have concerns regarding the denial of a claim for your dental services, you (or your authorized representative, if applicable) may request a review of the denial by filing an appeal.

To be considered an appeal:

The appealing party must file the request within 90 calendar days after the date of the notice of the initial denial termination (for example, within 90 calendar days of the date of the EOB informing the enrollee of a denied or reduced claim).

- The request must be in writing and may be either mailed or faxed. (Due to the requirements to verify the appealing party, electronically submitted appeals are not accepted.) The appeal should state the issue in dispute and should include a copy of all supporting documentation (e.g., a copy of the EOB) necessary for review.
- There must be a disputed question of fact which, if resolved in favor of the appealing party, would result in the authorization of benefits from the program.
- The issue must be appealable. Non-appealable issues are:
 - Regulatory provisions. Based on FHFA regulations, a dispute involving a regulatory provision or contractually defined issue of the FHFA Dental Insurance Program (such as which procedures are covered) is not processed as an appeal.
 - Allowable charge. The allowable amount or charge for a covered service is not appealable because the methodology for determining the amount or charge is established by the FHFA Dental Insurance Program contract.
 - Eligibility for the FHFA Dental Insurance Program. A person's eligibility to participate in the FHFA Dental Insurance Program is not appealable. Issues relating to eligibility are to be addressed directly with FHFA Human Resources.

- Denial of services by a dentist. The refusal of a dentist to provide services or to refer a beneficiary to a specialist is not an appealable issue. This type of correspondence is categorized as a grievance and is handled accordingly.

The following persons can submit an appeal of denied dental benefits under this program:

- The enrollee (including minors; however, a parent or guardian of a minor enrollee may represent the enrollee in an appeal).
- A representative of the enrollee who has been appointed by a court of competent jurisdiction to act on behalf of the enrollee.
- An individual who has been appointed, in writing, by the enrollee to act as his or her representative.

Send your written request for an appeal to:

Delta Dental of California
Federal Government Programs
P.O. Box 537015
Sacramento, CA 95853-7015

Grievances

Delta Dental's grievance process allows full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a participating network dentist or Delta Dental personnel to furnish the level or quality of care and/or service to which the enrollee believes he or she is entitled. For the process to work efficiently, it is important that any grievance be submitted in writing to Delta Dental as soon as possible after the occurrence of the initial event that is the subject of the grievance, and prior to the enrollee seeking additional care related to the initial event.

Delta Dental's policy is that any person enrolled in the program or other representative who is aggrieved by a failure or perceived failure of Delta Dental's staff or a participating network dentist to meet their obligations for timely, high-quality appropriate care or service may file a written grievance.

A grievance must state it is a "formal grievance" and must be submitted in writing.

Send your request for a grievance to:

Delta Dental of California
Federal Government Programs
P.O. Box 537015
Sacramento, CA 95853-7015

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding

a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.

Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt out of marketing that is permitted by law without an authorization. Delta Dental does not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

You have the right to be notified following a breach of unsecured protected health information.

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

COMPLAINTS

You may file a complaint with Delta Dental and/or with the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact Delta Dental at 888-497-0675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

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

This notice is effective on and after January 1, 2016.

Note: Delta Dental's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.

LANGUAGE ASSISTANCE

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-844-883-4288.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-844-883-4288. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-844-883-4288。(Chinese)

Last significant changes to this notice:

- Clarified that Delta Dental does not use your PHI for fundraising purposes - effective January 1, 2016
- Clarified that Delta Dental's privacy policy reflect federal and state requirements - effective January 1, 2015
- Updated contact information (mailing address and phone number) - effective July 1, 2013
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs - effective July 1, 2013
- Clarified that Delta Dental does not and will not sell your information without your express written authorization - effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) - effective July 1, 2013

DELTA DENTAL AND ITS AFFILIATES

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia. Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

Wellness efforts

Delta Dental understands the importance of your oral health and offers you some program enhancements to help you maintain healthy teeth and gums. The wellness library at deltadentalins.com/wellness is a one-stop shop for oral health-related tools, tips and resources for smiles of all ages. You can also check out *Grin!*, Delta Dental's e-magazine, for more oral health news and tips.

Delta Dental contact information

Most questions about the FHFA Dental Insurance Program can be answered by visiting the website at feds.deltadentalins.com/fhfa. By visiting the website, you can:

- Find a network dentist
- Download forms, view FHFA Dental Insurance Program materials
- Register to manage your account to view benefits details, check claims status, maximums used to date and sign up for paperless explanation of benefits statements
- Sign up for program updates
- Submit your questions using the online Customer Service Inquiry Form

You may also call Delta Dental's Customer Service department at **888-497-0675**. You can speak with a representative between the hours of 8 am and 8 pm. Eastern time, Monday through Friday, except holidays.

Dental offices can obtain a printout of your benefits by dialing **844-825-8111**.

Glossary

Many words contained in this benefits booklet have specific meanings. The following definitions are provided to help you better understand certain terms and get the most from the information contained in this guide.

Appeal

A formal procedure through which an enrollee in the FHFA Dental Insurance Program or an authorized representative can request a review of the denial of payment of a claim for covered dental services.

Assignment of benefits

This term refers to the authorization that a primary enrollee gives Delta Dental, by signing the appropriate section on the claim form, to send payment for any FHFA Dental Insurance Program covered services directly to the non-Delta Dental treating dentist.

Calendar year

The 12-month period beginning January 1 and ending December 31.

Calendar year deductible

The dollar amount that must be paid by the patient in a calendar year towards some covered services before benefits are applied to those services.

Calendar year maximum

The total dollar amount that will be paid by the plan toward the cost of dental between January and December. The patient is personally responsible for paying costs above the annual maximum.

Coinsurance

If the deductible is required to be met, the percentage of a claim that you are required to pay after Delta Dental has applied the benefit.

Coordination of benefits (COB)

A method of integrating benefits payable for the same patient under more than one dental plan. Benefits from all sources should not exceed 100% of the total charges. .

Delta Dental of California

A not-for-profit dental benefits administrator, Delta Dental of California is one of many Delta Dental Plans across the country that are members of Delta Dental Plans Association. Delta Dental of California administers the FHFA Dental Insurance Program.

Eligibility

The criteria set forth by the FHFA to determine who is allowed to enroll in the FHFA Dental Insurance Program.

Exclusions

Dental services and/or procedures not covered under the program.

Explanation of benefits (EOB)

A statement sent to the primary subscriber and to the dentist, when the dentist is paid directly by Delta Dental, showing dentist and patient information, the service(s) received, the allowable charge(s), the amount(s) billed, the amount(s) allowed by the program and the coinsurance amount(s). For denied services, the EOB also explains why payment was not allowed and how to appeal that decision.

Federal Government Programs

The division of Delta Dental of California that administers the FHFA Dental Insurance Program under a contract with the Federal Housing Finance Agency (FHFA).

Grievance

A formal procedure that offers an opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network dentist or Delta Dental personnel to furnish the level or quality of care and/or service to which the beneficiary believes he or she is entitled.

Network dentist

A licensed dentist who participates as a member of the specific network of dentists who have agreed to accept negotiated fees for the provision of affordable dental care to enrollees of the FHFA Dental Insurance Program. Besides agreeing to accept the program allowable fees as the full fee for covered treatment, network dentists have also agreed to complete and submit claims paperwork on behalf of FHFA Dental Insurance Program patients and to receive payment directly from Delta Dental.

Out-of-network dentist

A licensed dentist who is not a member of the participating the FHFA Dental Insurance Program network. While care may be received from an out-of-network dentist, subscribers may experience higher out-of-pocket costs than if using a participating network dentist.

Premium prepayment

An advance payment amounting to the first month's premium that is required to be made by at the time of application for enrollment in the FHFA Dental Insurance Program. Future monthly premiums are paid through electronic funds transfer (EFT) or recurring credit card payment (RCCP).

Pre-treatment estimate

A non-binding, written estimate of how much Delta Dental will cover for a particular service under the FHFA Dental Insurance Program. Pre-treatment estimate are suggested for the more complicated and expensive treatment plans.

Procedure codes

The American Dental Association (ADA) codes used to identify and define specific dental services. Only those dental services whose procedure codes are specifically listed in this benefits booklet are covered under the FHFA Dental Insurance Program.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

These companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 85 million people around the country. Operations in: Alabama, California, Delaware, District of Columbia, Florida, Georgia, Louisiana, Maryland, Mississippi, Montana, Nevada, New York, Pennsylvania, Puerto Rico, Texas, U.S. Virgin Islands, Utah and West Virginia.

