

OCC Dental Insurance Program



Dental Program Guide 2021

Plan Year Highlights

2021 Summary of Benefit Changes				
	Class I Services Diagnostic, Preventive	Class II Services Basic Restorative, Endodontics, Periodontics, Oral Surgery	Class III Services Major Restorative, Prosthodontics, Implants	Class IV Services Orthodontia
Revised	N/A	N/A	D5282, D5283, D5286, D6091	N/A
Deleted	N/A	D7960	N/A	N/A
New	D0701, D0705, D0706, D0707, D0708, D0709	D3471, D3472, D3473, D3501, D3502, D3503, D7961, D7962	N/A	N/A

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Introduction

Effective January 1, 2015, Delta Dental of California's Federal Government Programs division began administering dental benefits under the Office of the Comptroller of Currency (OCC) Dental Insurance Program for active and retired employees of the OCC, active employees of the Office of Financial Research (OFR), and their eligible family members.

Family members eligible for coverage under the program are a spouse or a domestic partner, unmarried children up to age 22, and unmarried children up to age 25 who are full-time students in an accredited institution of learning and who meet the certification requirements. Additionally, unmarried disabled children are eligible for coverage with no age limitation. Please contact OCC Human Resources if you have any questions regarding eligibility for family members.

The OCC Dental Insurance Program will provide you with:

- Quality, cost-effective dental coverage
- Two available options from which to choose – a PPO (preferred provider organization) option for active employees and OCC retirees, and a DHMO (dental health maintenance organization) option for active employees and OCC employees who retire on disability
- 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 OCC Dental Insurance Program to help with your program needs. At deltadentalins.com/occ, you can search for a network dentist, find program materials, and view Frequently Asked Questions (FAQs) as well as register to use the Consumer Toolkit®. Through the toolkit, you can access your personal information, print your PPO ID card, view the status of your PPO claims, print copies of your Explanation of Benefits (EOB) statements, and much more.

Call Delta Dental's Customer Service department at 844-883-4288 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 OCC Dental Insurance Program:

Website	deltadentalins.com/occ
Group Name	Office of the Comptroller of the Currency (OCC)
Customer Service	Toll-free phone number: 844-883-4288/844-309-9252 (International)/800-735-2922 (TTY/TTD) Representatives are available between 8:00 a.m. and 8:00 p.m. (Eastern time), Monday through Friday (excluding holidays).
24-Hour Dental Benefits Automated Number for Dentists	844-825-8111 (used by PPO option dentists to obtain a detailed fax of the dental benefits coverage)
Payer ID	CDCA1 (used by dentists when filing claims electronically)

Program Overview

The OCC Dental Insurance Program consists of two dental options: A preferred provider organization (PPO) and a dental health maintenance organization (DHMO). With Delta Dental as the program’s administrator, these two options are known as the Delta Dental PPOSM plan and the DeltaCare[®] USA (DHMO) plan. The following outlines who can enroll in which option.

If you are:	You can enroll in:
An OCC active employee	PPO or DHMO
An OFR active employee	PPO or DHMO
An OCC disabled retiree	PPO or DHMO
An OCC non-disabled retiree	PPO only

Although the PPO and DHMO options both provide a wide range of preventive, diagnostic, and basic and major restorative services as well as orthodontia, each option is structured differently. There is no waiting period to receive benefits under either option (please refer to the footnotes below the Plan Comparison chart for “Missing Tooth Limitation”).

Plan Comparison

The chart below provides an overview of both the PPO and DHMO options for your convenience in comparing the options. Please note that all PPO out-of-network services are paid based on usual and customary charges; therefore, you may pay higher out-of-pocket costs when using a non-network dentist.

Plan Features	PPO In-Network		PPO Out-of-Network**		DeltaCare USA (DHMO)****
	Plan Pays	You Pay	Plan Pays	You Pay	
Class I Diagnostic (e.g., exams, x-rays) Preventive (e.g., cleanings)	100%	0%	100%	0%	No Cost
Class II Basic Restorative (e.g., fillings) Endodontics (e.g., root canals) Periodontics (e.g., gum treatment) Oral Surgery (e.g., extractions)	80%*	20%*	80%*	20%*	Copayments range from \$0 – \$380
Class III*** Major Restorative (e.g., crowns, inlays/ onlays) Prosthodontics (e.g., partials/full dentures) Implants	60%*	40%*	60%*	40%*	Copayments range from \$10 – \$415 Optional treatment: limited to implant/ abutment supported crowns and dentures
Class IV Orthodontia (children and adults)	60%	40%	60%	40%	Copayments range from \$1,150 – \$2,100
Authorization for specialty care treatment	Preauthorization is not required		Preauthorization is not required		Your DeltaCare USA (DHMO) dentist will coordinate authorization for specialty care treatment†
Calendar Year Deductible (January 1 – December 31)	\$50 per person \$150 per family		\$50 per person \$150 per family		No deductible

DeltaCare USA is not available in MN and ND. In AK, CT, LA, ME, MS, MT, NH, NC, OK, SD, VT and WY, DeltaCare USA is provided as an open access plan; in these states, going to a DeltaCare USA dentist will maximize your savings under the plan. If you choose a non-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.

**Subject to the annual deductible.*

***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.*

****Missing Tooth Limitation - Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage limitation exists when it replaces a tooth extracted or otherwise missing prior to the effective date of coverage. For replacement of a missing tooth within 24 months of enrollment, the plan pays at 30%, and you will pay 70%. For 25 months and beyond, the plan pays at 60%, and you will pay 40%.*

****DeltaCare USA plan: If you enroll in the DHMO option, you will be sent complete information on covered services, policy limitations and benefit exclusions for the DeltaCare USA plan in your area. If you wish to review that information in advance of your enrollment, please contact the Delta Dental Customer Service department at 844-883-4288 and request a copy.*

† If a DeltaCare USA dentist determines that a patient requires services from a specialist and there is no DeltaCare USA specialist within the lesser of 35 miles or one hour commuting time, the patient will be authorized to seek treatment from a PPO, Premier or non-network specialist.

Eligibility

Full-time and part-time permanent employees of the OCC and OFR whose employment status is for 12 consecutive months or more are eligible to enroll in the OCC Dental Insurance Program. Employees who retire from the OCC are eligible to continue their participation in the program with the same eligible family members they had at retirement (a retiree cannot add eligible family members).

An employee can cover their spouse or domestic partner, unmarried children up to age 22 (which includes foster children, legally adopted children, and stepchildren), unmarried dependent children who are age 22 up to age 25 and are a full-time student (you must comply with the OCC full-time student certification requirement), as well as an unmarried dependent child who has been deemed totally disabled prior to attaining age 22.

Student Verification

Once an enrolled unmarried dependent child reaches age 22, the OCC Dental Insurance Program requires verification of the child's enrollment in an accredited college or university. Ninety days prior to your dependent child's 22nd birthday, Delta Dental will send you email notification (or written notification if no email is on file) of the requirement to supply documentation verifying full-time student status. You will have the option to submit the required documentation by mail, by fax or through the online inquiry feature located on the "Contact Us" page of the website at deltadentalins.com/occ. A copy of the student's college admission record showing the student is enrolled full-time (with at least 12 units for undergraduate or 9 units for graduate per semester) is required for verification. Delta Dental will update the child's eligibility upon receipt of the required documentation. If you fail to submit the required documentation as requested, your child's coverage will be cancelled as of his or her 22nd birthday.

In July of each year, Delta Dental will send you notification of the requirement to supply documentation verifying your child's full-time enrollment in an accredited college's or university's fall semester. You will be required to provide this documentation annually up to your child's 25th birthday or until your child has graduated, whichever comes first.

If coverage has been cancelled for a child who is under age 25, the child cannot become an eligible dependent again unless you re-enroll the child in the program during open season. Contact OCC Human Resources if you have questions regarding re-enrollment of a dependent child.

Manage Your Account – Website Registration

Once you have enrolled in the program, you are encouraged to “Manage Your Account,” located at deltadentalins.com/occ, to verify your enrollment and gain access to benefit and claims information.

To register, follow these steps:

1. Go to deltadentalins.com/occ.
2. Click on the appropriate tab at the top of the page for the dental option in which you are enrolled (Delta Dental PPO or DeltaCare USA DHMO).
3. On the right-hand side of the page in the **Manage Your Account** box, click on the “Register today” link.
4. Follow these instructions:
 - a. If you are enrolled in the Delta Dental PPO, 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)
 - 6) Username and Password (you personalize)
 - b. If you are enrolled in the DeltaCare USA – DHMO, enter your:
 - 1) User Type (select Enrollee, then click **Next**)
 - 2) First Name
 - 3) Last Name
 - 4) Enrollee ID (your social security number)
 - 5) Date of Birth (then click **Next**)
 - 6) Username and Password (you personalize)
5. 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. If an OCC employee is married to another OCC employee (or OFR employee married to another OFR employee) then they both must enroll under one family enrollment.

Note: If the spouse of an active OCC/OFR employee is also an active employee of the OCC/OFR, both persons must be enrolled in the OCC Dental Insurance Program under one family enrollment.

Enrollment

The opportunities for employees to enroll in the program or to add eligible family members, and the permitted timeframe to enroll, are as follows:

Opportunity	Timeframe	Tools	Effective Date
Newly Hired or Newly Eligible (initial enrollment opportunity)	31 days from date of hire or date you became eligible	Dental Enrollment Form which can be obtained from OCC Human Resources	1 st of the month following receipt of the form by OCC Human Resources
Life Events (e.g., birth, adoption, legal placement of a child, marriage, establishment of a domestic partnership, and a spouse who was enrolled in the program leaves OCC/OFR)	31 days from the date of the event	Dental Enrollment Form which can be obtained from OCC Human Resources (must submit supporting documentation verifying the event, e.g., birth certificate, marriage certificate, etc.)	1 st of the month following receipt of the form by OCC Human Resources
Open Season (annual opportunity that allows you to add dependents or change options)	4-week period during November and December of each year (period is announced by OCC Human Resources)	Dental Enrollment Form which can be obtained from OCC Human Resources	January 1 st

Once an employee has enrolled in the program, Delta Dental will send the new enrollee a welcome packet. The welcome packet is different for each of the dental options elected.

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

Employees who enroll in the DHMO option will receive a welcome packet by mail, sent to their home address on file. The welcome packet contains your personalized ID card, contact information for your contracted dentist, and an Evidence of Coverage document that includes a fee schedule for each covered procedure and a description of the benefits, policies and exclusions of your DeltaCare USA (DHMO) plan in your area.

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 OCC 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 OCC Human Resources receives the enrollment form.

Premiums

There is no cost to employees or their dependents for enrollment in the program. Your employer (OCC or OFR) will pay 100% of the premium.

Survivor Benefits

In the event of the death of an active employee, continued eligibility to participate in the program for a 24-month period at no cost will be extended to the deceased employee's dependents who are currently enrolled at the time of the active employee's death. OCC 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

An employee's coverage under the OCC Dental Insurance Program ends on his or her date of separation from the OCC or OFR. Coverage for dependents enrolled in the program will end when the employee's coverage ends or when a dependent no longer qualifies as an eligible family member.

Non-Disabled Retirees

As an employee participating in the program who retires from the OCC on a non-disability retirement, you have 31 days from your date of retirement to elect to continue your participation in the program. If you were enrolled in the PPO option, you can elect to continue to participate in the PPO option. If you were enrolled in the DHMO option, you can continue your participation in the OCC Dental Insurance Program only if you elect to switch to the PPO option.

Enrollment

When you retire from the OCC on a non-disability retirement, OCC Human Resources will provide you with written notification of a one-time opportunity to elect to participate in the OCC Dental Insurance Program as a retiree. You will have 31 days from your retirement date to make your election. If you elect to participate in the program as a retiree, that election will become effective the first of the month following the date you enroll. As a retiree, you are not permitted to add a dependent who was not actively participating in the OCC Dental Insurance Program at the time of your retirement. You are only permitted to cancel coverage of a dependent who is enrolled.

During the enrollment process you will be required to complete the Electronic Funds Transfer (EFT)/Recurring Credit Card (RCC) Payment Authorization form. As a non-disabled retiree, you will be required to pay for your coverage on a monthly basis. Payment will only be accepted electronically and you will be required to make a two-month initial prepayment to enroll. Once you have enrolled in the program as a non-disabled retiree, you will be able to manage your enrollment record through the Consumer Toolkit*. You will be able to delete dependents, change your address and email, and update your electronic payment information.

Delta Dental will send you a welcome packet to confirm your enrollment in the program as a non-disabled retiree. Note that ID cards are not necessary to obtain benefits under the PPO option; however, you can print an ID card that will display your name.

Premiums

Non-disabled retirees are required to make monthly premium payments electronically. The premium rates are:

OCC Retirees - Monthly PPO Premium Rates Effective January 1, 2021	
Single (retiree only)	\$ 47.38
Two Person (retiree and one dependent)	\$ 85.64
Family (retiree and two or more dependents)	\$155.02

Survivor Benefits

A surviving spouse and other dependents covered on a deceased non-disabled retiree's plan do not have the opportunity to continue participating in the OCC Dental Insurance Program beyond the retiree's date of death.

Termination of Coverage

Coverage for a retiree under the OCC Dental Insurance Program ends when the retiree stops making premium payments or upon the death of the retiree. Coverage for a retiree's dependents enrolled in the program will end when the retiree's coverage ends or when a dependent no longer qualifies as an eligible family member.

For complete information on enrolling in the OCC Dental Insurance Program PPO option as a retired OCC employee, please refer to the OCC Dental Insurance Program Fact Sheet for Retirees, available online at deltadentalins.com/occ.

Disabled Retirees

An employee participating in the program who retires from the OCC on a disability retirement will automatically be extended coverage in the program under the same option he or she had as an employee.

Enrollment

As a disabled retiree of the OCC, no action on your part is required to continue participating in the program. OCC Human Resources will handle the enrollment for you. As a disabled retiree, you are not permitted to add a dependent who was not actively participating in the program at the time of your retirement. You are only permitted to cancel coverage of a dependent who is enrolled.

If you would like a new ID card, log on to the Consumer Toolkit and print your card, or request one by contacting Delta Dental's Customer Service department at 844-883-4288.

Premiums

There is no cost to disabled retirees or their dependents for enrollment in the program. OCC will pay 100% of the premium.

Survivor Benefits

In the event of the death of a disabled retiree, continued eligibility to participate in the program for a 24-month period at no cost will be extended to the deceased disabled retiree's dependents who are currently enrolled at the time of the disabled retiree's death. OCC Human Resources will notify the deceased disabled retiree's dependents of continuation of coverage based on the survivor benefits provision under the program.

Termination of Coverage

A disabled retiree's coverage under the program will end upon the retiree's death or when the retiree no longer qualifies for disability under the retirement system that initially granted the approval, whichever comes first. Coverage for dependents enrolled in the program will end when the disabled retiree's coverage ends or when the dependent no longer qualifies as an eligible family member, whichever comes first.

Dentist Networks

Delta Dental offers three participating dentist networks. The two participating networks available to enrollees in the PPO option are the Delta Dental PPOSM network and the Delta Dental Premier[®] network. The participating network for those enrolled in the DHMO option is the DeltaCare[®] USA network. A list of dentists participating in these Delta Dental networks is available at deltadentalins.com/occ.

PPO Option Networks (Delta Dental PPO and Delta Dental Premier)

The PPO option allows you to visit any licensed dentist of your choice for treatment. Although the PPO option 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.

The following chart depicts typical savings you may expect when visiting a Delta Dental PPO network dentist or a Delta Dental Premier dentist as compared to the cost of treatment from a non-Delta Dental, non-contracted dentist. These are hypothetical numbers for illustrative purposes only and assume that no maximums or deductions apply.

Example	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non-Delta Dental/Non-Contracted Dentists*
Dentist's charge for a Class III service	\$1,000	\$1,000	\$1,000
Contract allowance (amount on which Delta Dental bases its payment)	\$640	\$800	\$900
Coinsurance (% of contract allowance Delta Dental will pay)	60%	60%	60%
Delta Dental's share	\$384	\$480	\$540
Enrollee's share	\$257	\$320	\$460*
Balance billing (any amount over the contract allowance that the enrollee is paying)	\$0	\$0	\$100

**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.*

DHMO Option Network (DeltaCare USA)

In most states, the DHMO option operates through a network of participating dentists who manage all your dental care. You will be required to select a primary care dentist, or one may be assigned to you. You pay a fixed copayment for services, and with the exception of emergencies, there is generally no coverage for out-of-network benefits. If you are covered by other dental insurance, coordination of benefits does not apply.

DeltaCare USA is not available in MN and ND. In AK, CT, LA, ME, MS, MT, NH, NC, OK, SD, VT and WY, DeltaCare USA is provided as an open access plan; in these states, going to a DeltaCare USA dentist will maximize your savings under the plan. If you choose a non-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.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

PPO Option

The PPO option provides both in-network and out-of-network benefits. Under this option, 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 a calendar year maximum and 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 option.

Summary of PPO Option Benefits

Benefits	In-Network		Out-of-Network**	
	Plan Pays	You Pay	Plan Pays	You Pay
<u>Class I: Diagnostic and Preventive Care and Emergency Care</u> <ul style="list-style-type: none"> Oral exams; full-mouth, bitewing, panoramic and periapical x-rays Routine cleanings, fluoride application, sealants, space maintainers Palliative (emergency) treatment to relieve pain 	100%	0%	100%	0%
<u>Class II: Basic Restorative Care, Endodontics, Periodontics, Prosthodontics, Oral Surgery and Anesthesia</u> <ul style="list-style-type: none"> Fillings Root canal therapy Osseous surgery, periodontal scaling and root planing Denture adjustments and repairs Extractions Anesthesia (deep sedation/general, IV moderate (conscious) sedation) 	80%*	20%*	80%*	20%*
<u>Class III***: Major Restorative Care, Implants and Prosthodontics</u> <ul style="list-style-type: none"> Crowns, inlays and onlays Surgical implants, implant crowns Dentures, bridges, and partials 	60%*	40%*	60%*	40%*
<u>Class IV - Orthodontia</u> <ul style="list-style-type: none"> Coverage for children and adults 	60%	40%	60%	40%
Authorization for specialty care	Preauthorization is not required			
Calendar Year Maximum (January 1 - December 31) Class I, II and III services	\$2,500			
Calendar Year Deductible (January 1 - December 31) Individual Family	\$50 per person \$150 per family			
Orthodontic Lifetime Maximum	\$2,000 for children and adults			

*Subject to annual deductible

** 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.

*** Missing Tooth Limitation - Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage limitation exists when it replaces a tooth extracted or otherwise missing prior to the effective date of coverage. For replacement of a missing tooth within 24 months of enrollment, the plan pays at 30%, and you will pay 70%. For 25 months and beyond, the plan pays at 60%, and you will pay 40%.

PPO Option Covered Services

Procedures that are covered under the OCC Dental Insurance Program's PPO option 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 current version of the ADA Current Dental Terminology (CDT). Below is a list of all of the covered services under the OCC Dental Insurance Program's PPO option.

Class I

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 - complete 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
D4910	Periodontal maintenance
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure
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Class II

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

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
- D4266 Guided tissue regeneration – 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 double pedicle graft, per tooth
- 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 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
- 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

Class III

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 – $\frac{3}{4}$ cast predominantly base metal

D2782 Crown – $\frac{3}{4}$ cast noble metal

D2783 Crown – $\frac{3}{4}$ 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 (male or female component) 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 Implant removal, by report
- 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 alloys

Prosthodontic 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
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)
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

Class IV

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
- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional 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))
- D8690 Orthodontic treatment (alternative billing to a contract fee)

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 total fee for individually listed radiographic images equals or exceeds the fee for a complete series, these radiographic images 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 (Class I 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. Two topical fluoride applications are covered in a calendar year period for children to age 19.
7. Space maintainers are only covered for dependent children under the age of 19.
8. Sealants are covered on permanent molars for children 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 (Class I 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 (Class II 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 (Class II 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 (Class II 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 (Class II 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 (Class II 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 (Class III Services)

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

Policy Limitations for Major Restorative Services (Class III 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 indicated 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.
11. Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage limitation exists when it replaces a tooth extracted or otherwise missing prior to the effective date of coverage. For replacement of a missing tooth within 24 months of enrollment, the plan pays at 30%, and you will pay 70%. For 25 months and beyond, the plan pays at 60%, and you will pay 40%.

Policy Limitations for Implant Services (Class III 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.
6. Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage limitation exists when it replaces a tooth extracted or otherwise missing prior to the effective date of coverage. For replacement of a missing tooth within 24 months of enrollment, the plan pays at 30%, and you will pay 70%. For 25 months and beyond, the plan pays at 60%, and you will pay 40%.

Policy Limitations for Prosthodontic Services (Class III 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.
17. Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage limitation exists when it replaces a tooth extracted or otherwise missing prior to the effective date of coverage. For replacement of a missing tooth within 24 months of enrollment, the plan pays at 30%, and you will pay 70%. For 25 months and beyond, the plan pays at 60%, and you will pay 40%.

Policy Limitations for Adjunctive General Services (Class III 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 (Class IV Services)

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. Orthodontic treatment (alternative billing to contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.
8. 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.
9. 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.
10. Post-operative orthodontic records including radiographs, models and records taken during treatment are included in the fee for the orthodontic treatment.
11. When a patient transfers to a different orthodontic dentist, payment and any additional records, etc. will be subject to review and recalculation of benefits.

12. 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.

PPO Option 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 OCC 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 deltadentalins.com/occ.

For Delta Dental to process your PPO option 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: Office of the Comptroller of the Currency
- 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

PPO option 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 for covered services should be completed and submitted to Delta Dental as soon as possible after services have been provided. 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

Under the PPO option, requests for pre-treatment estimates are not required but are recommended. For procedures performed under Class II, Class III and Class IV services, 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)

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 PPO option are as follows:

- COB pertains to you only if you are enrolled in the PPO option.
- If you are in the PPO as the primary enrollee 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 OCC Dental Insurance Program is primary.
- If you are enrolled in the PPO as the primary enrollee *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 OCC 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 OCC Dental Insurance Program will pay primary, unless the other dental plan is considered primary then OCC will pay as secondary.
- If your spouse has his or her own dental plan, claims for the spouse's dental services are to be filed with that plan first.

- 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.)

Dental carriers coordinate benefits when other coverage is noted on the claim, allowing patients to maximize their coverage under both programs—so 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 OCC 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.

DHMO Option

The DHMO option under Delta Dental's OCC Dental Insurance Program is referred to as the DeltaCare® USA (DHMO) plan. The usual requirements of the PPO option—such as claims, annual deductibles, coinsurance, balance billing, and annual and lifetime benefit maximums—do not apply under the DHMO plan. The DeltaCare USA (DHMO) plan is easy to use and offers you a combination of quality and affordability. The plan is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

Some advantages to the DHMO option are:

- All-inclusive copayments, with no additional costs for noble and high noble metal, porcelain, resin and lab fees
- Posterior composites (tooth-colored) fillings on posterior teeth
- Additional cleanings and periodontal maintenance (not limited to one per six-month period)
- Teeth whitening
- Orthodontic extractions
- Deep sedation/general anesthesia/IV sedation
- Occlusal guards and adjustments

Under the DHMO option, you must select a dentist who participates in the DeltaCare® USA network as your primary care dentist (PCD). All your dental needs will be provided to you by your PCD. For your family, you can select different PCDs. You are required to select a PCD at the time of your enrollment or one will be selected for you. You can change your PCD selection at any time. To select a new DHMO primary care dentist from the DeltaCare USA network, simply call Delta Dental Customer Care at 844-883-4288 and select Option 1 to speak with a DHMO representative to change your primary care dentist. The representative will assist you with that change. Changes to PCDs are processed by Delta Dental on the 20th of the month and will become effective the first of the following month.

You will pay a copayment for covered services rendered by your DHMO dentist in accordance with the DHMO fee schedule. Generally, there are no out-of-network benefits under the DHMO option. However, if you are traveling beyond the normal commuting distance of your PCD (the lesser of 35 miles or a one-hour commute time) and require emergency dental services, you can see any licensed dentist in that area for palliative treatment only and pay for the services

in full. Submit a dental claim form and the complete bill to Delta Dental at the following address for claim consideration with a maximum of \$100 reimbursement per emergency:

DeltaCare USA
P.O. Box 1810
Alpharetta, GA 30023

Call Delta Dental's Customer Service department at 844-883-4288 for answers to any questions you have regarding the DHMO option under this program.

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 OCC regulations, a dispute involving a regulatory provision or contractually defined issue of the OCC 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 OCC Dental Insurance Program contract.
- Eligibility for the OCC Dental Insurance Program. A person's eligibility to participate in the OCC Dental Insurance Program is not appealable. Issues relating to eligibility are to be addressed directly with OCC 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 according.

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.

For the PPO option, send your written request for an appeal to:

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

For the DHMO option, send your request for an appeal to:

For residents in California:	For residents in all other states:
DeltaCare USA	DeltaCare USA
Quality Assessment	Quality Assessment
P.O. Box 6050	P.O. Box 1860
Artesia, CA 90702	Alpharetta, GA 30023

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.

For the PPO option, send your request for a grievance to:

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

For the DHMO option, send your request for a grievance to:

For members in California:	For members in all other states:
DeltaCare USA	DeltaCare USA
Professional Services, Quality Management	Professional Services, Quality Management
P.O. Box 6050	P.O. Box 1860
Artesia, CA 90702	Alpharetta, GA 30023

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 844-883-4288, 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.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Dentegra Insurance Company.

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 SmileWay® Wellness site at deltadentalins.com/occ 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 OCC Dental Insurance Program can be answered by visiting the website at deltadentalins.com/occ. By visiting the website, you can:

- Find a PPO or DHMO network dentist
- Download forms, view OCC Dental Insurance Program materials
- Get dental health and wellness information with the SmileWay wellness site
- 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 844-883-4288. You can speak with a representative between the hours of 8:00 a.m. and 8:00 p.m. Eastern time, Monday through Friday, except holidays. International callers can reach a Delta Dental Customer Service representative at 844-309-9252 (TTD/TTY: 800-735-2922).

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 OCC 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 OCC 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 PPO option 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.

Copay/Copayment

A copay or copayment is the amount of money you are required to pay directly to the dentist each visit under the DHMO option.

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 OCC Dental Insurance Program.

Eligibility

The criteria set forth by the OCC to determine who is allowed to enroll in the OCC 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 in the PPO Option 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 OCC Dental Insurance Program under a contract with the Office of the Comptroller of the Currency (OCC).

Fee Schedule

A list of the charges agreed to by a dentist and Delta Dental for specific dental services under the DHMO option.

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 OCC 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 OCC 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 OCC 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 OCC 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 OCC 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 OCC Dental Insurance Program.

