

Federal Government Programs

Dental Office Handbook



Dear Doctor and Staff:

We are pleased to present the Dental Office Handbook for dental programs administered by the Federal Government Programs (FGP) division of Delta Dental of California. Currently, these programs include:

- Federal Employees Dental Program (FEDVIP)
- Veterans Affairs Dental Insurance Program (VADIP)
- Public Health Service Active Duty Dental Program (PHS ADDP)
- Office of the Comptroller of the Currency (OCC) Dental Insurance Program

We have developed this Handbook to provide your office with easily obtainable reference materials for each of our program's benefits, policies and procedures. This Handbook may be revised from time to time, so if you plan to print a paper copy for your office, please check the program websites periodically to ensure you have the latest version. This Handbook is an extension of the Delta Dental Participating Legion Dentist Agreement with regard to program benefits, limitations and exclusions, processing policies, and Quality and Utilization Management.

We think you will find the information in both in this Handbook and on our websites to be helpful. We welcome any suggestions and recommendations to make this Handbook more valuable to you and your office staff in providing services to enrollees in FGP dental programs.

Thank you for your continued support as a Delta Dental network dentist. We greatly appreciate the care you provide each and every day to patients enrolled in Delta Dental's many programs, especially those administered by the Federal Government Programs division of Delta Dental of California.

Sincerely,

Delta Dental of California
Federal Government Programs Division

Table of Contents

Contact Information	1
Web Services	2
Dental Office Toolkit®	2
Direct Deposit	3
Online Dentist Inquiry form	3
SmileWay® Wellness Program	3
About Delta Dental's Networks	4
Delta Dental Legion	4
Delta Dental PPO™/DPO	4
Delta Dental Premier®	4
Changes to your Records	4
Joining the Delta Dental Legion Network	5
Dental Office Support	6
When to File Claims	6
Claims Submission Tips	6
National Provider Identifier (NPI)	7
Taxpayer Identification Number	8
Electronic Attachments	8
Claims Payment	8
Pre-treatment Estimates	9
Waiver of Copayment	9
Non-covered and Optional Services	9
Coordination of Benefits	10
– Birthday Rule	10
– Custody Cases	11
Orthodontic Claims	11
Processing Policy Codes	12
Administrative Policy (AP) Codes	12
Exclusions and Limitations (EL) Codes	12
Missing Information (MI) Codes	12
Program Policy (PP) Codes	12
Quality Management	12
Utilization Management	13
TRICARE Retiree Dental Program	14
Federal Employees Dental Program	15
Summary of Benefits	16
Federal Employees Dental Program Policies, Covered Benefits, Limitations and Exclusions	17
Covered Services for High and Standard Plan Options	17
Veterans Affairs Dental Insurance Program	35
Summary of Benefits	36
Enhanced Plan – Policies, Covered Benefits, Limitations and Exclusions	37
Comprehensive Plan – Policies, Covered Benefits, Limitations and Exclusions	40
Prime Plan – Policies, Covered Benefits, Limitations and Exclusions	52
Public Health Service Active Duty Dental Program	70
Office of the Comptroller of the Currency Dental Insurance Program	71
Summary of PPO Option Coverage	72
PPO Option Covered Services	73
Glossary	89

Contact Information

Enrollment and benefits verification for Federal Government Programs:

> Dental Office Toolkit (DOT) (<https://ddfgptoolkits.com>)

For more detailed information on the benefits of using DOT, see the Web Services section of this Handbook.

> Interactive Voice Response (IVR) system, including a Fax-back Option

The Fax-back provides a summary of the program's coverage; a list of some of the most requested services by CDT code, including frequency limitations; and the last service date (when available).

> Your practice management software

Your practice management software provides enrollment and benefit information using the HIPAA 270/271 transaction set standard. Generally, this information includes:

- Subscriber ID, group number and name/address
- Dependent information, including relationship and date of birth
- Basic coverage information
- Original coverage effective date
- Annual contract period
- Annual maximum and deductible (total and to-date amounts)
- Percentage of benefit payment by coverage category

Please check with your software vendor for the specifics on the type of information that is obtainable from your practice management system.

Provider Relations email address: FSPS@delta.org

Toll-free Customer Service number for dental offices: 844-825-8111

Federal Employees Dental Program deltadentalins.com/fedvip

Claim Submission/Written Inquiries:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

Public Health Service Active Duty Dental Program phsaddp.com

Claim Submission/Written Inquiries:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

Veterans Affairs Dental Insurance Program deltadentalins.com/vadip

Claim Submission/Written Inquiries:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

OCC Dental Insurance Program deltadentalins.com/occ

Delta Dental PPO™ Plan

Claim Submission/Written Inquiries:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

DeltaCare® USA Plan

Claim Submission/Encounter Forms:

DeltaCare USA
PO Box 1810
Alpharetta, GA 30023

Web Services

If you can't find what you're looking for in this handbook, try searching one of our program websites. Each website was designed with both the enrollee and dental office in mind, and you'll find each one to be a great resource for program-specific information, news and updates. Other reference guides are available online as well. And best of all, the information is available when you need it—24 hours a day, seven days a week.

When you use the websites, everything you need to know about a particular program is at your fingertips—so there is no need to pick up the phone and call us. Each website is set up with “Quick Links” to provide easy access to those online self-service tools you will use most often, like the Dental Office Toolkit® (DOT) and the Dentist Inquiry Form.

Dental Office Toolkit®

The Dental Office Toolkit® (DOT) is designed to help decrease time spent each day on the administrative tasks involved in providing care for patients covered under FGP's dental programs. This dynamic, online self-service tool allows you to:

- **Check eligibility information.**
Use DOT to check the eligibility of your FGP patients.
- **Retrieve benefit information.**
Access specific benefit information for eligible patients, such as coverage levels, cost shares, and annual maximum and deductibles remaining.
- **Submit claims and pretreatment estimates.**
With DOT, you can submit your own claims and pretreatment estimates online and eliminate paper claims or the costs that most clearinghouses charge you for submitting your claims electronically. Sign up for direct deposit and get your claims payments faster, too.
- **Check claims status.**
Find out the status of your claims and pretreatment estimates submitted online through DOT—without having to call us.
- **Edit and delete submitted claims.**
Make same-day changes to your claims or delete claims even after you have submitted them for processing—quickly, efficiently, and all online.

When you first register for DOT, you will need to create a username and unique password. To protect your password and authenticate each time you log in to the toolkit, you will be asked to select and answer a “secret” question so we can identify you in the future when you make a password change.

After you register for the DOT, we'll send you an email including an attached letter with full instructions on how to activate your new DOT account. We will also send a copy of the letter to your service office mailing address; please note that if we do not have a service office email address on file, your office will need to wait until the letter arrives in the mail before you can activate and begin using your DOT account.

Once you have activated your account, your office will be able to use all the features of DOT. If you register for DOT and do not receive an email or copy of the letter, contact Delta Dental at 844-825-8111.

Transmission of personal and/or private information is secure with DOT. Federal regulations such as the Health Insurance Portability and Accountability Act (HIPAA) that mandate the protection of individually identifiable patient information from public access ensure that your privacy and that of your patients is maintained in DOT. Encrypted transmission between your computer system and DOT is secured using a 128-bit SSL (Secured Socket Layers) encryption program; this encryption nearly eliminates any possibility that personal information could be intercepted prior to its secure storage at Delta Dental. While it is impossible to guarantee absolute security, Delta Dental makes extraordinary efforts that surpass both industry standards and HIPAA requirements in order to protect your information throughout our operating systems.

With no cost to submit claims or use any of the features of this self-service tool and the advanced security measures that are taken to ensure your privacy, there is no reason not to use DOT. You can use DOT for all your FGP patients, regardless of what federal program they are enrolled in. Additional information about DOT, including a list of frequently asked questions, is available on any of the program websites.

Direct Deposit

Once you have activated your DOT account, you will have the ability to sign up for direct deposit of your claim payments.

Signing up for direct deposit allows your claim payments to be transferred electronically from Delta Dental directly into your bank account. With direct deposit, there is no more waiting for the check to be delivered to your office by mail.

The advantages of direct deposit include:

- **Fast payments:** Payment is usually made within 48 hours of claims submission.
- **Safety:** There's less chance of lost or stolen checks. Simply view your claim payment information in your Dental Office Toolkit Activity Log, or in your practice management system.
- **Efficiency:** With no mail to sort or checks to deposit, your office staff saves valuable time. Your claim payment remittance advice and Explanation of Benefits (EOB) statements are all online!

Claim payment checks and EOBs are mailed weekly to dental offices within a specific ZIP code range. Depending on the ZIP code range in which your office falls, you might have to wait several weeks before you receive your payment. Using direct deposit will eliminate long wait times—payments will be deposited automatically into your bank account within days of processing!

You can find the FGP Direct Deposit form online in the Dentist section of our website, under "Resources"; you can also access the form in the DOT. Print the form, then complete the required information. There is no need for a voided check—simply enter your banking information on the form, sign it and mail it to us at the address shown on the form. Once we receive your form, we'll enter your information directly into our secure system. For reconciliation purposes, you can access DOT or use the viewer in your practice management system to see your deposit and remittance advice/electronic EOB — it's faster, safer and more efficient than waiting for the mail!

Online Dentist Inquiry Form

Have a question about how a claim was processed? Need clarification on a predetermination notification form? Want to know what a specific processing policy code means? Don't wait to call: Use the online Dentist Inquiry Form instead and submit your questions to us 24 hours a day, seven days a week. You'll receive a response usually within 24 hours. Here are just a few uses for the online Dentist Inquiry Form:

- Obtaining enrollment or benefits information for a specific patient
- Providing a response to an Information Request (IR) letter we sent to you regarding a claim
- Getting instructions on how to update your office information
- Requesting information on becoming a participating network dentist

SmileWay® Wellness Program

Each of our websites offers a link to Delta Dental's SmileWay Wellness site. This site is a one-stop shop, with oral health-related tools, tips and resources for your patients' use. Be sure to check it out and tell your patients about the various topics available to them, such as "Healthy Aging," "Mouth-Body Connection" and "Dental Treatments". The SmileWay Wellness site is just one more way Delta Dental goes the extra mile for you and your patients.

About Delta Dental's Networks

Delta Dental Legion

Delta Dental's Legion network dentists are "contracted" dentists who are exclusive to national programs offered under Federal contracts. Delta Dental Legion Network Dentists agree to provide services at contracted fees that meet cost-management criteria. The Delta Dental Legion network was formerly known as the Delta Dental SelectUSA network.

Delta Dental PPO™/DPO

Delta Dental's PPO (preferred provider organization) network dentists are "contracted" dentists in Delta Dental's fee-for-service plans, which allow enrollees to visit any licensed dentist but may offer incentives when choosing PPO network dentists. Delta Dental PPO network dentists agree to provide services at fees that meet the plan's cost-management criteria. In Texas, this network is known as a dental provider organization, or "DPO."

Delta Dental Premier®

Delta Dental Premier network dentists are "contracted" dentists in Delta Dental's fee-for-service plans, which allow enrollees to visit any licensed dentist; they offer advantages such as no balance billing and the convenience of claims submission, even when they are considered "out of network" for the enrollee's plan.

Changes to Your Dentist Record

To ensure that your claims are processed accurately, claim payments are made in a timely manner and your office is listed correctly on the online Dentist Directory, it is important that you keep information regarding your network agreement current and that you update your contact and billing information whenever there are changes. If your office address, business name, taxpayer identification number (SSN, TIN or EIN) and other information about your practice is not maintained and updated as needed, it can adversely affect the way in which Delta Dental processes your claims.

If you participate in the Delta Dental Premier network and/or the Delta Dental PPO/DPO network, you will need to contact your local Delta Dental member company to make any changes in your information. You can find contact information for all the local Delta Dental member companies on any of our program websites. Once the local Delta Dental member company has updated your information, changes will occur in the Delta Dental National Provider File (NPF) which will in turn update your information within the entire Delta Dental system, including Federal Government Programs.

To request changes specific to your Delta Dental Legion participating dentist network agreement, please email, fax, or mail your request to the address below:

Email: FSPS@delta.org

Fax: 916-858-4810

**Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007
Fax: 916-858-4810**

Please allow 30 days from the time they are requested for changes to be reflected in all Delta Dental files.

Joining the Delta Dental Legion Network

The Delta Dental Legion dentist network is exclusive to national programs offered under federal contracts and administered by Delta Dental of California.

It's easy to join the Delta Dental Legion network; simply email a request for a Legion Application and Agreement packet to FSPS@delta.org. The packet will be sent to you in the manner you request (email, fax or USPS). Please include the necessary information for us to complete the request to include the:

- Dentist's full name
- Service office location
- Phone number
- Fax number

Return the completed and signed application/attestation and agreement, along with the required credentialing documents (per the checklist), to the Federal Government Programs division in one of three ways:

- **Email to:** FSPS@delta.org
- **Fax to:** 916-858-4810
- **Mail to:** Delta Dental of California
Federal Government Programs
PO Box 537007, Sacramento, CA
95853-7007

Delta Dental is required to verify the professional qualifications of dentists requesting participation in the Delta Dental Legion Network. Each treating dentist's credentials are verified (through a primary or secondary verification process) as part of the initial application to join the Delta Dental Legion Network with recredentialing no less than every three years thereafter. The recredentialing process is initiated within 180 days prior to the end of the three-year period.

Delta Dental's credentialing process is based on federal, state and other regulatory agencies' standards to include NCQA and URAC. The process involves verifying each treating dentist's submitted information with various regulatory agencies, professional associations and educational institutions to ensure that the dentist is legally qualified to practice dentistry.

Delta Dental uses specific credentialing criteria and guidelines to verify that dentists meet and maintain the required standards for participation in each Delta Dental network as follows:

- Completed Application, Attestation and Agreement, signed and dated
- Valid and current state dental license to practice, with no current actions on the licensure
- Valid, current registrations/permits, including those for DEA, conscious sedation, oral conscious sedation and/or general anesthesia, when applicable
- Board Certification of specialty/residency completion, if applicable
- Current Professional Liability Insurance coverage with minimum amounts required of \$1,000,000/\$3,000,000 or the amount that meets the requirement of the state/territory where the dentist holds his/her license and provides services, whichever is greater.
- History of professional liability claims, including previous lawsuits, if any
- Query of the National Practitioner Data Base (NPDB) for further verification of all information (SSN is required for query purposes)
- Query of the DHS OIG (U.S. Department of Health and Human Services Office of the Inspector General) for federal sanctions (including Medicare and Medicaid)
- Prior work history

All information submitted for the credentialing process is kept confidential. Failure to participate in the credentialing/rec credentialing activities may result in the suspension of claim payments to a contracted dental office and/or termination from participation in the Delta Dental Legion network.

Dental Office Support

When to File Claims

We encourage the dental office to submit claims for federal government program enrollees to Delta Dental as soon as possible after completing the treatment. For a federal government program patient's claim to be considered for reimbursement, Delta Dental must receive the claim within 12 months following the month in which the services were provided. In cases where this requirement differs from your local Delta Dental member company's practice, federal provisions prevail with respect to claims for federal government program patients. Delta Dental will deny payment for any claim that is not submitted within the specified time limitation. Additionally, Delta Dental dentists may not charge a patient who is covered under a federal government program for any amount that would otherwise be payable by Delta Dental if the claim had been submitted within the required timeframe unless the patient failed to tell the dentist that he or she was covered under a federal program.

Claims Submission Tips

We will accept claims submitted electronically as well as paper claims sent through the mail. It is important that you mail paper claims to the correct address listed on the Contact Page of this handbook.

Please use our payer ID number **CDCA1** when submitting claims electronically. You can submit claims electronically through the Dental Office Toolkit® or using a practice management vendor/clearinghouse.

When we receive a paper claim, it is first scanned by machine and then guided through our processing system using Optical Character Recognition (OCR) technology. This technology converts the scanned claim image into encoded and readable text that allows the claim to be edited, searched, stored and displayed electronically.

Here are a few tips to help ensure your claims are processed quickly and error-free:

- Use black ink/printer toner.
- Use the same font style and size throughout the claim (all-cap, 10-point font is recommended).

- Dates should be in "MMDDYYYY" format with no spaces, dashes or slash marks.
- Use the "Remarks" or "Comments" field ONLY to document exceptional or unusual circumstances on the claim.
- Indicate fees with decimal points (for example, \$100.00, not \$100).
- Indicate a quantity (for example, radiographic images) in the field on the claim specifically for this purpose.
- Indicate the tooth number or letter, quadrant or arch in the appropriate field(s).
- Use the correct indicator (tooth number/letter, quadrant or arch) for the corresponding CDT code.
- Use the same business name and associated tax identification number (TIN) as the IRS has on file for the billing entity for the service office location. The Type 2 National Provider Identifier (NPI) can be included with this information (see "National Provider Identifier" below for more information).
- Indicate the treating dentist's name, license number and issuing state, and the Type 1 National Provider Identifier (NPI) on the claim (see "National Provider Identifier" below for more information).
- Do not send study models; they are not reviewed.

Try to avoid these common errors, which can cause processing inaccuracies and delays and possible denial of a claim:

- Illegible handwritten claims
- Using ink colors other than black (preferred) or dark blue
- Using free-form text or stamped information in the body of the claim
- Using ditto marks or arrows to indicate duplicate information
- Making marks in spaces that should be left blank
- Putting a slash through zeroes, or crossing sevens
- Writing on the top of lines or outside of boxes
- Using correction fluid or a highlighter pen
- Submitting photocopied claims that may be blurred or skewed
- Using nicknames for either/both the enrollee and/or dependents

- Submitting a new claim when requesting that an incorrect claim be reprocessed. Instead, make notations or corrections directly on the Explanation of Benefits (EOB), attach any additional information required, and submit the EOB for reprocessing.

You can review the details for each procedure code under the program-specific sections of this handbook. Procedure code details available in these sections include the percentage covered by the program; applicable waiting periods, frequencies and/or time limitations, and deductibles and maximums; and documentation requirements such as radiographic images or reports/narratives.

National Provider Identifier (NPI)

What is a National Provider Identifier?

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires providers who submit claims electronically or who check claims status or access patient eligibility and/or benefits information online to obtain a National Provider Identifier (NPI). All individual health care providers, including dentists and organizations such as clinics and group practices, are eligible to obtain an NPI. The National Plan and Provider Enumeration System (NPPES), a third-party entity, is responsible for processing applications and assigning NPI numbers under the authority of the federal government.

An NPI is a 10-digit number unique to each health care provider or organization. It contains no coded information about the provider or organization and is a permanent identifier that never changes or expires. An NPI replaces other identifying numbers currently used in electronic transactions, such as

those used by Medicaid, Blue Cross/Blue Shield, UPIN, CHAMPUS, etc. However, the NPI cannot be used in place of social security, DEA, taxpayer identification (TIN/EIN) or state license numbers, or specialty identifiers (e.g. taxonomy).

Do you need an NPI?

If you answer “yes” to any one of the following questions, you are required by federal law to obtain and use an NPI:

- Do you submit claims electronically?
- Do you use a clearinghouse?
- Do you submit claims attachments electronically?
- Do you use the Internet or Internet applications to obtain eligibility, benefits information or check claims status?

Which NPI is Right for You?

There are two types of NPIs. A Type 1 NPI is assigned to individual health care providers such as dentists and hygienists and is the only type of NPI you need if you receive payments in your name as a solo practitioner. Practices with multiple dentists should obtain a Type 1 NPI for each dentist. A Type 2 NPI is used by incorporated businesses, such as group dental practices and clinics, and other business entities paid under their business or corporate name. Please see the table below.

How do you apply for an NPI?

To apply for a Type 1 or Type 2 NPI, visit <https://nppes.cms.hhs.gov>. Complete the application, then follow the instructions to submit it online or by mail. (Faxed applications are not accepted.) Once receipt of your application is confirmed, you should receive your NPI within one to five business days via email if you submitted the application online; applications sent by mail may require up to 20 days to process.

Dental Practice Type	NPI Type Required
Solo practitioner	Type 1 if claims are submitted in the dentist’s name and SSN is used as taxpayer ID
Individual dentist at one practice location	Type 1 for the dentist and Type 2 for the practice if claims are submitted in the practice DBA name and associated practice/business payer ID is used
Multiple dentists at one practice location	Type 1 for each dentist and Type 2 for the practice if claims are submitted in the practice DBA name and associated practice/business payer ID is used
Multiple dentists at multiple practice locations	Type 1 for each dentist and Type 2 for the specific practice location and practice/business payer ID

Using the Type 2 NPI to identify the payee in conjunction with the Type 1 NPI to identify the treating dentist is acceptable, although **the treating dentist's Type 1 NPI is always required for electronic claims submission.**

The Type 1 NPI must match the Delta Dental National Provider File (NPF). If it does not match or is missing, the electronically submitted claim will be disallowed with the appropriate processing policy code(s). It is important to check with your local Delta Dental member company to verify that your NPI information has been added correctly to the NPF, as well as with your practice management software vendor to ensure that the Type 1 NPI is not dropped completely or changed to the Type 2 NPI (business) during electronic claim transmission.

Taxpayer Identification Number

It is important that both your taxpayer identification number (TIN), employer identification number (EIN) or social security number (SSN) and your practice name on file with Delta Dental match your IRS records. If the records do not match exactly, the IRS requires Delta Dental to withhold 28 percent of any future claim payments we make to you until the mismatched record is corrected. This can be avoided by following these tips when submitting your claims:

- If you use two or more names for your practice (such as John Smith, DMD, ABC Dental), please submit your claim using only the name that appears as the first listing on your IRS record (either the dentist or DBA name).
- If you are not certain how your practice name and the associated TIN/EIN/SSN are recorded with the IRS, check the mailing labels that the IRS provides you for your quarterly tax payments or contact the IRS to request a letter (#147C) that confirms how your name and taxpayer ID are listed.

Electronic Attachments

You can transmit claims electronically and include any required attachments (such as radiographs and narratives) with FastAttach®. This service, available through National Electronic Attachment, Inc. (NEA), eliminates the need to submit paper claims that require attachments. FastAttach® lets you transmit digitized x-rays, periodontal charts, Explanation of Benefits (EOB) documents, photos and narratives along with your electronic claims.

Using NEA's FastAttach® service to submit required documentation electronically is a simple, cost-effective way to streamline your office administration. Lost or damaged attachments

and postage, printing and photocopying costs are eliminated, and the need to follow up with payers is greatly reduced. To use FastAttach®, your computer system must meet the following requirements

- Windows 2000 or higher, with current Windows updates
- Monitor and video card capable of 32-bit color
- Internet Explorer 6.0 or higher
- High-speed Internet connection
- Electronic claims transmission capability, included with practice management systems, using either a direct-to-payer website (such as DOT) or a clearinghouse.

For more information about FastAttach®, visit NEA's website at www.nea-fast.com.

Claims Payment

For any single procedure that is a covered service (with the exception of orthodontic treatment as described in this handbook), Delta Dental makes payment upon completion of the procedure. Payment is applied to any deductible and maximum available on the date of service, regardless of when the claim is submitted.

Delta Dental network dentists will receive an EOB for each claim processed. The patient will also receive an EOB. Delta Dental dentists may collect only up to the approved amount indicated on the EOB. Claim payments will be sent directly to all Delta Dental dentists regardless of whether or not they are considered participating network dentists for the specific federal government program. When services are provided by a non-Delta Dental dentist, Delta Dental will send payment to the patient. Delta Dental sends one check for all claims processed during a single payment cycle. Delta Dental schedules claim payments weekly based on ZIP code ranges. Claim payments are mailed on specific days of the week to dental offices in a particular ZIP code range. (This includes payment for all claims processed during the week prior to the payment date.) For example: Your office ZIP code is 99999 and claim payments for ZIP code 99999 are mailed every Wednesday. If we process a claim for you on Thursday, your payment for that claim will be mailed to you on Wednesday of the following week.

Note: *Delta Dental may automatically recover overpayment of a claim from future payment checks that may or may not be for claims submitted on behalf of the same patient for whom the overpayment was originally made.*

Pre-treatment Estimates

Although pre-treatment estimates are not required, we recommend them for more complex and/or expensive procedures such as cast crowns, bridges, dental implant services and dentures. If you are uncertain whether or not a particular service is covered under any of the federal programs, or if you or the patient wants an estimate of the amount the program will pay for the service, you should submit a pre-treatment estimate request. A pre-treatment estimate request should include the same information required to process a claim, such as specific procedure code(s), treatment plan, and reports or x-rays, if needed. Only the dates of service should be left blank, since the treatment is only proposed and not yet completed.

When Delta Dental processes the pre-treatment estimate request both the dentist and the patient will receive a pre-treatment estimate notice. A pre-treatment estimate notice is a non-binding, written estimate of how much the program covers for a particular service. Pre-treatment estimates are valid up to 12 months from the date of issue. After 12 months, pre-treatment estimates are deleted from our files.

Once the services have been performed, insert the dates of service, sign and date the pre-treatment estimate notice and submit it as a claim for payment. Delta Dental will make a final determination of program eligibility, maximums, benefits, limitations and allowable fees at the time of submission of the pre-treatment estimate notice after services performed are indicated on the form. *If you submit pre-estimated services on a new claim form rather than on the pre-treatment estimate notice, Delta Dental will treat the claim as new and will require x-rays and/or other supporting documentation as necessary to process it.*

Waiver of Copayment

Each federal government dental program covers services at various percentages. The remaining percentage of the allowed fee is the patient's copayment. Calculation of the copayment is based on the fee allowed by the program, not the dentist's regular charges.

Delta Dental network dentists who participate in any federal government dental program must make reasonable efforts to collect the full amount of the patient's copayment. Offering to accept Delta Dental's payment as payment in full or routinely failing to collect the patient's full copayment ("waiver of copayment") is considered a form of fraud known as "overbilling."

Overbilling has been identified by the American Dental Association as unethical conduct and is specifically prohibited by law in many states. Delta Dental investigates all suspected cases of overbilling, and violations may result in the termination of all the dentist's participating Delta Dental network agreements.

Non-covered and Optional Services

Delta Dental's federal programs are designed to deliver affordable, quality dental care to enrollees. To ensure that enrollees in these programs are aware of their financial obligations, a contracting dentist is required to obtain a signed financial agreement prior to providing optional or non-covered benefits. Any form may be used for this purpose as long as it specifies the fees associated with the optional or non-covered service. The dentist may not bill or collect from an enrollee any charges in connection with a non-covered or optional dental service that is more expensive than is customarily provided unless an executed Financial Responsibility or Optional Treatment Form has been obtained from the enrollee or the enrollee's legal representative per the following guidelines:

- If the annual maximum has been exhausted, the dentist may bill the enrollee at the approved Delta Dental fee for the non-covered/optional service.
- The network dentist agrees to charge no more for optional treatment than the difference between the dentist's filed and approved Delta Dental fee for the optional treatment and the amount allowed by the program for the covered procedure.
- The dentist and the enrollee or the enrollee's authorized representative must sign a document agreeing to the above financial terms.

Coordination of Benefits

Coordination of Benefits (COB) is the process carriers follow to ensure that the combined benefits of all dental programs under which a patient is covered are utilized to their maximum extent. Following are some basic claim submission guidelines to help maximize your patient's dental benefits while making sure that the total payment does not exceed 100 percent of the combined fees allowed by all carriers:

- First determine which carrier is primary.
- Submit the claim to the primary carrier and include complete information about the secondary carrier.
- Once the primary carrier has processed the claim, send a claim to the secondary carrier indicating the amount the primary carrier paid in the appropriate box on the claim form, even if the primary carrier paid zero.

Coordinating benefits between dental plans can often be challenging and more complex than simply applying standard primary and secondary coverage rules. We have listed the COB rules below to help you gain a better understanding of how coverage and payment is determined in most dual coverage situations. For possible exceptions to these rules, be sure to check your patient's benefits booklet for any dental plan not included in this handbook.

- If the subscriber has another dental plan that is principally a dental program, the plan that was effective first would be the first to pay. In this instance, the OCC Dental Insurance Program is always the primary coverage UNLESS the subscriber's other coverage is through the Federal Employees Health Benefits (FEHB) Program or the Federal Employees Dental and Vision Insurance Program (FEDVIP).
- Delta Dental will generally make the first payment if the other coverage is not principally a dental program. *An exception to this rule applies to two Delta Dental programs: the Federal Employees Dental Program (FEDP) and the Office of the Comptroller of the Currency (OCC) Dental Insurance Program. For patients enrolled in FEDP who also have coverage with one of the FEHB carriers, FEHB will always be primary and should be billed for all dental services provided as the primary coverage. For patients enrolled in the OCC Dental Insurance Program who also have coverage under any of the FEHB or FEDVIP carriers, their FEHB or FEDVIP coverage will be primary.*

- If the spouse has his or her own dental plan that is principally a dental program, claims for the spouse's dental treatment should be filed with that plan first.
- Private insurance carriers are primary when the patient is also covered under a state-funded program such as Medicaid.
- When Delta Dental is secondary, the combined payments made by Delta Dental and the other coverage carrier will not exceed the approved charges.
- For patients covered by both an active and an inactive plan (e.g. a retiree who is employed), coverage received as the active employee is primary, and the coverage under the retirement plan is secondary.
- Medical plans may be primary when an accident has caused the need for dental treatment (such as a broken tooth resulting from a fall or a car accident). A patient's medical coverage carrier would also be primary if the group dental plan contract indicates coverage for specific oral procedures such as a biopsy, oral surgery provided by a physician or dental treatment provided in a hospital. Check the patient's benefits booklets for both plans to help you determine when a medical plan is primary.

Birthday Rule

To comply with the contractual requirements of each of the federal agencies that oversee the programs we administer, Delta Dental must adhere to the "birthday rule" as defined by the National Association of Insurance Commissioners (NAIC). This rule determines the primary carrier for dependent children who are covered under two different plans and defines the primary insurance carrier as the carrier of the parent whose birthday (month and day only) occurs earliest in the calendar year. For example, if the dependent child's mother was born on May 1 and the father was born on May 5, the mother's plan is the primary carrier and the first to pay. The parents' birth years do not matter; only the months and days of birth are considered under the birthday rule.

Custody Cases

In cases where a dependent child of divorced parents has dual coverage, the following rules apply:

- If one parent has been awarded custody, the custodial parent's insurance carrier pays first and the non-custodial parent's carrier pays second.
- If the custodial parent remarries, the custodial parent's insurance carrier pays first and the stepparent's carrier pays second.
- If the custodial parent does not have coverage but the child's stepparent does, then the stepparent's coverage pays first and the non-custodial parent's coverage, if applicable, pays second.
- If the parents share custody of the dependent child and there is no specific court decree establishing that one parent has more responsibility for the child than the other, the "birthday rule" applies.
- In special cases, a court may determine that other exceptions to these rules apply.

Orthodontic Claims

Unlike other services which are payable upon completion, orthodontic services are payable over the course of treatment. Claims for orthodontic treatment must include the following:

- Diagnosis
- Treatment plan, using current ADA CDT codes
- All-inclusive total fee
- Banding/appliance placement date
- Estimated duration of active treatment

Only one claim with the above information should be submitted to Delta Dental. Delta Dental makes an initial payment for approved orthodontic claims, followed by three automatic progress payments at six-month intervals as measured from the banding/appliance date, benefit eligibility and subject to continuing enrollment eligibility.

For all Delta Dental network dentists, the approved fee is the network allowance. The patient can only be billed up to the approved fee. When orthodontic treatment is covered under the program, there is a lifetime maximum; however, payment for diagnostic services performed in

conjunction with orthodontics is not applied to either the patient's annual maximum or lifetime orthodontic maximum.

Each orthodontic payment is subject to validation of the patient's enrollment status. Any progress payments are adjusted and/or discontinued accordingly.

- The patient must be enrolled at the time the progress payment is scheduled.
- If the patient's enrollment is terminated during the schedule of progress payments, no further progress payments are made.
- If a patient's enrollment is terminated and the patient re-enrolls during the original schedule of progress payments, a new claim must be submitted at the time the patient becomes eligible for orthodontic coverage.
- 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.
- When a patient transfers to a different orthodontic dentist, payment and any additional charges involved with the transfer of an orthodontic case, such as changes in treatment plan, additional records, etc., will be subject to review and recalculation of benefits.

Each orthodontic payment is also subject to validation of the dentist's status.

- If a dentist who does not participate in any Delta Dental network becomes a Delta Dental dentist during the schedule of progress payments, the progress payments are sent directly to the dentist rather than to the patient. If a Delta Dental dentist discontinues all participation with Delta Dental during the schedule of progress payments, the progress payments are sent to the patient.
- In the unlikely event that a dentist's license status changes (because of lost licensure or decertification by the federal government) during the schedule of progress payments, such payments would be discontinued as of the effective date of the loss of authorized status. In the case of federal program decertification, the patient is not liable for the subsequent fee charges unless a formal agreement is reached between the patient and the decertified dentist.

Provider requests for Delta Dental to investigate disputes must be submitted in writing. Document the details of the dispute and specify the desired outcome on the Provider Dispute Form, found on the program website. Include a copy of all records, documents, billing statements, etc., to support the dispute. An acknowledgment letter will be sent within five business days from receipt of the form. Upon receipt and throughout the review process, continual correspondence will be provided to all applicable parties including interim responses and final resolution.

Processing Policies

When processing claims, Federal Government Programs uses the Delta Dental National Processing Guidelines established by the Delta Dental Plans Association (DDPA). In some situations, we are obligated by our group contracts to process claims differently from the DDPA guidelines or local Delta Dental Member Company claims processing. Additionally since all programs administered by the Federal Government Programs division are offered under a contract with federal authority, processing is required to be in accordance with federal laws which may have preemption over certain state and/or local laws.

A Delta Dental Participating Network Dentist is subject to procedures adopted by Delta Dental to assess the quality and appropriateness of care provided to eligible patients, including but not limited to, furnishing to Delta Dental in a timely manner copies of clinical treatment records, radiographic images, and other requested documents. Procedures identified with the letter "X" require the submission of dated, labeled, current diagnostic radiographic images appropriate for the procedure. Duplicate radiographic image or copies must be of diagnostic quality, including paper copies of digitized images. Periapical radiographic images depicting the apex are preferable when submitting for crowns and fixed partial dentures. These requirements ensure services are provided at a level of care which meets professionally recognized standards of practice and that all services are readily available to each enrollee consistent with good professional practice.

To assist the dental office in better understanding the processing of claims, Federal Government Programs has established Processing Policy Codes that are categorized as follows:

Administrative Policy (AP) Codes:

- Are used for Information purposes and generally do not require any further action by the dental office.

Exclusion and Limitation (EL) Codes:

- Provide an explanation as to why a service was denied or disallowed based on the program's benefits, limitations and exclusions.

Missing Information (MI) Codes:

- Indicate services that are unable to be processed, resulting in a "denial" of the service(s). In order for Delta Dental to process the service(s),

the dental office can using the Explanation of Benefits (EOB) statement include the missing information on the EOB or attach the information to the EOB for reprocessing and/or reconsideration and return to the address listed on the EOB.

Program Policy (PP) Codes:

- Processing policies applicable to claims processing based on overall guidelines by a participating provider.

Claims can be resubmitted for reconsideration if treatment has been denied, disallowed or adjusted. The EOB form is required for the reconsideration and should include any information (narrative, clinical treatment records, radiographic images, etc.) that will allow the claim to be reconsidered. Do not send in a new claim as it may be denied as a duplicate claim.

All providers may file a dispute of a claim that has been denied, adjusted or contested. The provider must submit a written dispute to Delta Dental within 365 days of the action precipitating the dispute.

Document the details of the dispute and specify the desired outcome using the Provider Dispute Form found on the program website. Include a copy of all clinical treatment records, documents, billing statements, etc., to support the dispute.

A letter will be sent within five business days acknowledging the receipt of the Provider Dispute form by Delta Dental. Upon receipt and throughout the review process, continual correspondence will be provided to all applicable parties including interim responses and final resolution.

Quality Management

General Standards

1. Emergency care shall be available 24 hours a day, 7 days per week. An active after-hours mechanism, such as an answering machine, answering service, a cell phone number, or pager is available via 24-hour/7-day contact or other instructions.
2. Urgent care shall be provided within 72 hours when consistent with the patient's individual needs and required by generally accepted standards for dentistry.

3. Dental office facility and equipment must be clean, safe, well-maintained and in good repair.
4. Dental office must have written emergency protocols for fire and natural disasters which include a plan indicating escape routes, staff member responsibilities and where to call for assistance.
5. Sterilization and infection control standards must conform to the current “CDC Guidelines for Infection Control in Dental Healthcare Settings”.
6. A comprehensive collection of medical history should be taken to include but not limited to:
 - a. General health and appearance, systemic disease, allergies and reactions for anesthetics
 - b. Record of all current medications and medical treatment
 - c. Record of current physician and contact in case of emergency
 - d. Medical alerts (diabetes, high blood pressure, heart conditions, etc.) should be conspicuously located on a portion of the patient chart used during treatment and should reflect current medical history.
 - e. Periodic updates should occur in the patient chart at appropriate intervals, signed and dated by both patient and dentist.
7. Documentation of baseline dental conditions to include but not limited to:
 - a. Existing restorations and conditions
 - b. Missing teeth
 - c. TMJ and occlusal evaluation
 - d. Current existing prosthetics
 - e. Periodontal condition
 - f. Soft tissue – oral cancer exam
8. Documentation of patient’s chief complaint or pertinent information relative to patient’s dental history
9. Progress notes – legible, detailed, in ink, and in chronologic order.
 - a. Use of local anesthetic used – type and volume or noted “no local anesthetic used”.
 - b. Medications prescribed or dispensed for the patient.
 - c. Quantity and frequency of radiographic images taken (or refusal of radiographic images to be taken)
 - d. Written treatment plan

- i. Sequenced
- ii. Informed Consent form
- e. Oral Hygiene Instructions (OHI)
- f. Diagnosis and outcomes of treatment provided
- g. Specialty referrals

Utilization Management

The Utilization Management (UM) program includes the following:

- Benefit limitations and exclusions based on the enrollee’s plan
- Processing policies – both Delta Dental National Processing guidelines and any program contractual guidelines
- Procedure based reviews by a dentist consultant
- Analytic systems to identify atypical utilization of dental procedures, and
- Focused review of specific dentists

Delta Dental analyzes and evaluates the utilization of services to ensure that treatment is necessary and appropriate; claims submission complies with billing, documentation and benefits guidelines; and identifies dentists who provide services outside the community standard of care. Consideration is given to individual patient needs and clinical circumstances. Decision making is based on appropriateness of care and service and existence of coverage. There are no financial incentives for dentist consultants to encourage decisions that result in underutilization.

As part of the Quality and Utilization Management programs, Delta Dental may require providers to obtain prior authorization for some or all dental services. Providers may be required to submit additional x-rays and/or documentation to substantiate the need for the treatment requested or to demonstrate that the quality of the treatment performed is consistent with generally accepted standards of care. Diagnostic radiographic images should be current, dated and labeled as necessary and appropriate for the procedure. Duplicate radiographic images or copies must be of diagnostic quality, including paper copies of digitized images. Periapical radiographic images depicting the apex are preferable when submitting for crowns and fixed partial dentures.

TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) contract and dental benefits under the current Department of Defense program ended on December 31, 2018. However, dental coverage for military retirees and family members is offered under a new program. This change, contained in the 2016 National Defense Authorization Act (NDAA 2017), means military retirees and family members will have the option to select a dental plan through the Federal Employee Dental and Vision Insurance Program (FEDVIP) with coverage effective January 1, 2019.

Federal Employees Dental Program

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is offered under the authority of Public Law [108-496, Federal Employees Dental and Vision Benefits Enhancement Act of 2004] and is administered by the Office of Personnel Management (OPM). Both federal employees and annuitants (retirees) are eligible for coverage under FEDVIP.

Delta Dental is one of 10 dental carriers selected by OPM to offer coverage under FEDVIP; because ours is a dental-only program with no vision-care component, it is referred to as the “Federal Employees Dental Program.” Delta Dental’s seven-year contract with OPM for the Federal Employees Dental Program began January 1, 2014 and continues through December 31, 2020.

Delta Dental’s Federal Employees Dental Program offers two plan options: Standard and High. Benefits are the same under both plans options; however, coverage percentages, deductibles and annual maximums vary between the Standard and High plan options.

The Federal Employees Dental Program is a national program, providing access to a broad network of dentists within the service area that includes the 50 United States, the District of Columbia and Puerto Rico. The Delta Dental PPO network (DPO in Texas) is the participating network for the Federal Employees Dental

Program. For the states of South Dakota and Wyoming only, the Delta Dental Premier network is also considered a participating network for Federal Employees Dental Program enrollees.

Federal employees and annuitants who are eligible for coverage can select a carrier during their annual “Open Season” which is typically held in late fall. New federal employees are allowed to select a plan within 60 days of their employment. Changes cannot be made during the year unless there is a “qualifying life event” as defined by OPM.

Federal employees may be enrolled in a Federal Employees Health Benefits (FEHB) plan, combined medical and dental coverage. The dental office should verify with the patient if he or she has FEHB coverage and if so, request to make a copy of the FEHB identification card with the carrier information. Delta Dental’s Federal Employees Dental Program (FEDP) will always be the secondary payer for dental services when the patient has FEHB coverage that includes any dental benefits. The FEHB carrier should be billed as the primary carrier for all the dental services rendered the patient under these circumstances. Payment made for the services by the FEHB carrier should be included on the claim submitted to Delta Dental as the secondary payer; this should include a zero amount if no payment was made by the primary FEHB carrier.

Summary of Benefits

Service Category	Plan Summary of Benefits by Network Percentage			
	Standard Plan		High Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Basic Services – Class A Diagnostic Preventive	100% 100%	60% 60%	100% 100%	90% 90%
Intermediate Services – Class B Minor Restorative Endodontic Periodontic Prosthodontic Oral Surgery	55% 55% 55% 55% 55%	40% 40% 40% 40% 40%	70% 70% 70% 70% 70%	60% 60% 60% 60% 60%
Major Services – Class C Major Restorative Endodontic Periodontic Prosthodontic	35% 35% 35% 35%	20% 20% 20% 20%	50% 50% 50% 50%	40% 40% 40% 40%
Orthodontic Services – Class D (children under age 19)	50%	50%	50%	50%
General Services	55%	40%	70%	60%
Deductible - Class A services (in-network) are exempt from deductible	\$0	\$75	\$0	\$50
Annual Maximum (non-orthodontic)	\$1,500	\$600	\$30,000	\$3,000
Orthodontic Maximum (lifetime)	\$2,000	\$1,000	\$3,500	\$3,500
Orthodontic Waiting Period	12 months	12 months	12 months	12 months

Federal Employees Dental Program Policies, Covered Benefits, Limitations and Exclusions

General Policies

All services covered under the Federal Employees Dental Program are subject to the following general policies:

1. All dental services should be billed to the Federal Employees Health Benefits (FEHB) carrier as the **primary payer** when the patient has coverage under a FEHB plan with any dental benefits. Delta Dental will always be the secondary payer under these circumstances. When submitting a claim to Delta Dental as the secondary payer, indicate the amount paid by the FEHB plan, including zero if no payment was made, directly on the claim.
2. Services must be necessary to preserve functionality and maintenance of oral health to the teeth and supporting structures and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of their liability prior to treatment and the patient chooses to receive the treatment. Participating dentists shall document such notification in their records.
3. The plan must provide an alternate benefit provision for benefits beyond the least expensive professionally accepted standard of care, whereby the patient pays the difference between the covered benefit and the more expensive treatment option.
4. An appeal is not available when the services are determined to be unnecessary or do not meet accepted standards of dental practice unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. This is because such services are not billable to the patient, and there would be no amount in dispute to consider at appeal.
5. Procedures should be reported using the American Dental Association's (ADA) current dental procedure codes and terminology.
6. Claims submitted for payment more than 12 months after the month in which a service is provided are not eligible for payment. A participating dentist may not bill the enrollee for services that are denied for this reason.

7. Services, including evaluations, which are routinely performed in conjunction with or as part of another service, are considered integral. Participating dentists may not bill members for services denied if they are considered integral to another service.
8. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable to participating dentists by either the contractor or the enrollee.
9. Local anesthesia is considered integral to the procedure(s) for which it is provided.
10. Payment for diagnostic services performed in conjunction with orthodontics may be applied to the member's annual maximum.
11. All dental services (exclusive of orthodontia) will have an annual maximum benefit of \$1500 per year or greater when provided by an in-network dentist.

Covered Services for High and Standard Plan Options

- All benefits are subject to the definitions, limitations, and exclusions as outlined and are payable only when determined necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is \$0 for services when provided by a dentist who is "in-network."
- If an "out-of-network" dentist provides the services, there is a \$50 deductible per person for the High Plan option and a \$75 deductible for the Standard Plan option. Each enrolled covered person must satisfy his/her own deductible, as neither option contains a family deductible.
- The annual maximum in the High Plan option is \$30,000 for non-orthodontic services when the services are provided by a network dentist and \$3,000 when services are provided by an out-of-network dentist. The annual maximum in the Standard Plan option is \$1,500 when services are provided by a network dentist and \$600 when services are provided by an out-of-network dentist.
- In no instance will Delta Dental's Federal Employees Dental Program allow more than \$30,000 in combined benefits under the High Plan option in any plan year, nor more than \$1,500 in combined benefits under the Standard Plan option in any plan year.
- The waiting period for Class D orthodontic services is 12 months. To meet this requirement the dependent child receiving orthodontic services must be covered under the same plan for the

entire 12-month waiting period and must continue orthodontia benefits in the same orthodontia-vested plan option.

- Alternate benefits: If more than one service can be used to treat the dental condition, an alternate treatment may be authorized for an appropriate, less costly covered service.
- Any dental service or treatment not listed as a covered service is not eligible for benefits.

Class A – Basic Services

High Plan Option

- **In-Network:** 100% for covered services as defined by the plan and subject to plan deductibles and maximums.
- **Out-of-Network:** 90% of the plan allowance for covered services as defined by the plan and subject to deductible and annual maximum, per person.

Standard Plan Option

- **In-Network:** 100% for covered services as defined by the plan subject to plan deductibles and maximums.
- **Out-of-Network:** 60% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.

Diagnostic Services

D0120	Periodic oral evaluation
D0140	Limited oral evaluation—problem focused
D0145	Oral evaluation for a 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 set of radiographic images including bitewings
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

Preventive Services

D1110	Prophylaxis—Adult
D1120	Prophylaxis—Child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride—excluding varnish
D1351	Sealant—per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient—permanent tooth
D1510	Space maintainer—fixed—unilateral
D1516	space maintainer—fixed—bilateral, maxillary
D1517	space maintainer—fixed—bilateral, mandibular
D1520	Space maintainer—removable—unilateral
D1526	space maintainer—removable—bilateral, maxillary
D1527	space maintainer—removable—bilateral, mandibular
D1575	Distal shoe space maintainer—fixed—unilateral
D1550	Recementation of space maintainer

The following are additional procedures covered as Class A Basic Services:

D9110	Palliative (emergency) treatment of dental pain—minor procedure
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The following services are not covered:

- Plaque control programs
- Oral hygiene instruction
- Dietary instructions
- Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss
- Any exclusions or limitations listed under “General Exclusions”
- Charges for missed appointments
- Filling out paperwork
- Submitting claim forms
- Sterilizing instruments

Class B – Intermediate Services

High Plan Option

- **In-Network:** 70% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.
- **Out-of-Network:** 60% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.

Standard Plan Option

- **In-Network:** 55% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.
- **Out-of-Network:** 40% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.

Minor 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

The following services are not covered:

- Restorations, including veneers, which are placed for cosmetic purposes only
- Gold foil restorations
- Any exclusions or limitations listed under “General Exclusions”

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 junction 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)

Periodontic Services

D4341	Periodontal scaling and root planing—four or more teeth per quadrant
D4342	Periodontal scaling and root planing—one to three teeth, per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
D4910	Periodontal maintenance
D7921	Collection and application of autologous blood concentrate product

Prosthodontic Services

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)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
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)
D6930	Recent fixed partial denture
D6980	Fixed partial denture repair, 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 of residual tooth roots (cutting procedure)
D7251	Coronectomy—intentional partial tooth removal
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Exposure of an unerupted tooth
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
D7971	Excision of pericoronal gingiva
D7999	Unspecified oral surgery procedure, by report

Class C – Major Services

High Plan Option

- **In-Network:** 50% of the network allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.
- **Out-of-Network:** 40% of plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.

Standard Plan Option

- **In-Network:** 35% of the network allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.
- **Out-of-Network:** 20% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.

Major Restorative Services

D0160	Detailed and extensive oral evaluation – problem focused, by report
D2510	Inlay – metallic – one surface
D2520	Inlay – metallic – two surfaces
D2530	Inlay – metallic – three surfaces
D2542	Onlay – metallic – two surfaces
D2543	Onlay – metallic – three surfaces
D2544	Onlay – metallic – four or more surfaces
D2740	Crown – porcelain/ceramic
D2750	Crown – porcelain fused to high noble metal
D2751	Crown – porcelain fused to predominately base metal
D2752	Crown – porcelain fused to noble metal
D2780	Crown – 3/4 cast high noble metal
D2781	Crown – 3/4 cast predominately base metal
D2782	Crown – 3/4 cast noble metal
D2783	Crown – 3/4 porcelain/ceramic
D2790	Crown – full cast high noble metal
D2791	Crown – full cast predominately base metal
D2792	Crown – full cast noble metal
D2794	Crown – titanium
D2950	Core buildup, including any pins when required
D2954	Prefabricated post and core, in addition to crown

D2980	Crown repair necessitated by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2983	Veneer repair necessitated by restorative material failure

The following services are not covered:

- Gold foil restorations
- Protective restoration
- Restorations for cosmetic purposes only
- Composite resin inlays
- Any exclusions or limitations listed under “Allowable Exclusions and Limitations”

Endodontic Services

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
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.)
D3410	Apicoectomy – anterior
D3421	Apicoectomy – premolar (first root)
D3425	Apicoectomy (each additional root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling – per root
D3450	Root amputation – per root
D3920	Hemisection (including any root removal), not including root canal therapy

Periodontal 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
- 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 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
- D4355** Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit.
- D4381** Localized delivery of antimicrobial agents via a controlled release vehicle into diseases crevicular tissue, per tooth

Prosthetic Services

- 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 base (including any conventional clasps, rests and teeth)
- D5214** Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
- D5221** Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
- D5222** Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
- D5223** Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5224** Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5282** Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary
- D5283** Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular

D6010	Surgical placement of implant body: endosteal implant	D6075	Implant supported retainer for ceramic FPD
D6013	Surgical placement of mini implant	D6076	Implant supported reatiner for porcelain fused metal FPD (titanium, titanium alloy, or high noble metal)
D6055	Connecting Bar - implant supported or abutment supported	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6056	Prefabricated abutment - includes placement	D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6057	Custom fabricated abutment - includes placement	D6090	Repair implant supported prosthesis, by report
D6058	Abutment supported porcelain/ceramic crown	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	D6094	Abutment supported crown (titanium)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	D6095	Repair implant abutment, by report
D6061	Abutment supported porcelain fused to metal crown (noble metal)	D6096	Remove broken implant retaining screw
D6062	Abutment supported cast metal crown (high noble metal)	D6100	Implant removal, by report
D6063	Abutment supported cast metal crown (predominantly base metal)	D6194	Abutment supported retainer crown for FPD (titanium)
D6064	Abutment supported cast metal crown (noble metal)	D6210	Pontic - cast high noble metal
D6065	Implant supported porcelain/ceramic crown	D6211	Pontic - cast predominately base metal
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	D6212	Pontic - cast noble metal
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	D6214	Pontic - titanium
D6068	Abutment supported retainer for porcelain/ceramic FPD	D6240	Pontic - porcelain fused to high noble metal
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	D6241	Pontic - porcelain fused to predominately base metal
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	D6242	Pontic - porcelain fused to noble metal
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	D6245	Pontic - porcelain/ceramic
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6074	Abutment supported retainer for cast metal FPD (noble metal)	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 predominately base metal
D6752	Retainer crown – porcelain fused to noble metal
D6780	Retainer crown – 3/4 cast high noble metal
D6781	Retainer crown – 3/4 cast predominately base metal
D6782	Retainer crown – 3/4 cast noble metal
D6783	Retainer crown – 3/4 porcelain/ceramic
D6790	Retainer crown – full cast high noble metal
D6791	Retainer crown – full cast predominately base metal
D6792	Retainer crown – full cast noble metal
D6794	Retainer crown – titanium
D9999	Unspecified adjunctive procedure, by report

Class D – Orthodontic Services

High Plan Option

- **In-Network:** 50% of the network allowance up to the lifetime maximum of \$3,500. Patient is responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the lifetime maximum of \$3,500. Patient is responsible for all charges that exceed the lifetime maximum.

Standard Plan Option

- **In-Network:** 50% of the network allowance up to the lifetime maximum of \$2,000. Patient is responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the maximum of \$1,000. Patient is responsible for all charges that exceed the lifetime maximum.

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
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
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690	Orthodontic treatment (alternative billing to a contract fee)

The following services are not covered:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- 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 restoration for misalignment of teeth.
- Orthodontics for subscriber or spouse, or dependent children age 19 and older.

General Services

High Plan Option

- **In-Network:** 70% of the Network Allowance for covered services as defined by the plan, subject to plan deductible and maximum.
- **Out-of-Network:** 60% of the Network Allowance for covered services as defined by the plan, subject to plan deductible and maximum.

Standard Plan Option

- **In-Network:** 55% of the network allowance for covered services as defined by the plan and subject to plan deductible and maximum.
- **Out-of-Network:** 40% of the network allowance for covered services as defined by the plan and subject to plan deductible and maximum.

Anesthesia 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 Intravenous Sedation
D9243	Intravenous moderate (conscious) sedation/analgesia— <u>each subsequent 15 minute increment</u>

Consultations

D9310	Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician
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Office Visits

D9440	Office visit—after regular scheduled hours
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Medications

D9610	Therapeutic parenteral drug, single administration
D9612	Therapeutic parenteral drugs, two or more administrations, different medications

Post-Surgical Services

D9930	Treatment of complications (post-surgical)—unusual circumstances, by report
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Miscellaneous Services

D9944	Occlusal guard—hard appliance, full arch
D9945	Occlusal guard—soft appliance, full arch
D9946	Occlusal guard—hard appliance, partial arch

Allowable Exclusions and Limitations for Standard and High Plan Options

General Policies

All covered services are subject to the following general policies:

1. Services must be necessary to preserve functionality and maintenance of oral health to the teeth and supporting structures and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of their liability prior to treatment and the patient chooses to receive the treatment. Participating dentists shall document such notification in their records.
2. The plan must provide an alternate benefit provision for benefits beyond the least expensive professionally accepted standard of care, whereby the patient pays the difference between the covered benefit and the more expensive treatment option.
3. An appeal is not available when the services are determined to be unnecessary or do not meet accepted standards of dental practice unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. This is because such services are not billable to the patient, and there would be no amount in dispute to consider at appeal.
4. Procedures should be reported using the American Dental Association's (ADA) current dental procedure codes and terminology.
5. Claims submitted for payment more than 12 months after the month in which a service is provided are not eligible for payment. A participating dentist may not bill the enrollee for services that are denied for this reason.
6. Services, including evaluations, which are routinely performed in conjunction with or as part of another service, are considered integral. Participating dentists may not bill members for services denied if they are considered integral to another service.
7. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable to participating dentists by either the contractor or the enrollee.
8. Local anesthesia is considered integral to the procedure(s) for which it is provided.

9. Payment for diagnostic services performed in conjunction with orthodontics may be applied to the member's annual maximum.
10. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative endodontic x-ray is required for consideration if the endodontic therapy has not been submitted to the Contractor for payment.
11. Internal bleaching of discolored teeth (D9974) is eligible once per tooth per three-year period.

Benefits and Limitations for Diagnostic Services

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a calendar year.
2. One comprehensive evaluation (D0150) is allowed in a calendar year.
3. One limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-month period.
4. Re-evaluations are considered integral procedures.
5. Detailed and extensive oral evaluations (problem-focused) are limited to once per patient per dentist, per life of the contract.
6. Pulp vitality tests are considered integral to all services.
7. A comprehensive oral examination/evaluation (D0150) is payable once per dentist or group practice per year. Additional examinations/evaluations are considered periodic examinations/evaluations and are paid as such.
8. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two in a calendar year limitation on examinations/evaluations.
9. A full-mouth series (complete series) of radiographs includes bitewings. Any additional radiographic image taken with a complete radiographic series is considered integral to the complete series.
10. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.
11. Payment for more than one of any category of full-mouth radiographs 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 films.

12. A panoramic radiograph taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitation. Payment for panoramic radiograph is limited to one within a 48-month period.
13. Payment for periapical radiographic images (other than as part of a complete series) is limited to four within a calendar year except when done in conjunction with emergency services and submitted by report.
14. 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.

Benefits and Limitations for Preventive Services

1. Two routine prophylaxes are covered in a calendar year.
2. 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.
3. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.
4. 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.
5. Two topical fluoride applications are covered in a calendar year.
6. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.
7. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.
8. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

9. Space maintainers are only covered for dependent children under the age of 19.
10. The tooth number of the space to be maintained is required when requesting payment for space maintainers.
11. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.
12. Only one space maintainer is paid for a space, except under unusual circumstances (where changes due to growth patterns or additional extractions make replacement necessary).
13. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.
14. Repair of a damaged space maintainer is not covered.
15. Recementation of space maintainers is payable once within 12 months.
16. Sealants are covered on permanent molars through age 18. 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.
17. Sealants for teeth other than permanent molars are not covered.
18. Sealants provided on the same date of service and on the same tooth as a restoration of the occlusal surface are considered integral procedures.
19. Sealants are covered for prevention of occlusal pit and fissure type cavities; sealants done for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.
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 dentist, regardless of the number of combinations of restorations placed.
7. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.
8. Restorations are not covered when performed after the placement of any type of crown or onlay, on the same tooth and by the same dentist, unless approved by the contractor.
9. The payment for restorations includes all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
10. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension, are not covered.
11. 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 patient, per tooth, per lifetime.

Benefits and Limitations for Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
12. The charge for a crown or onlay should include all charges for work related to its placement including, 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.
13. Onlays, permanent single crown restorations, and posts and cores for members 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.) and is approved by the contractor.

14. 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.
15. Cast posts and cores (D2952) are processed as an alternate 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 by the Contractor for the prefabricated post and core.
16. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, 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, onlay, buildup, or post and core is not and cannot be made serviceable. Satisfactory evidence must show that the existing crown, 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.
17. 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 onlay, crown, or post and core.
18. 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.
19. Recementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts is eligible once per 6-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
20. 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.
21. 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.
22. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.
23. Posterior restorations not involving the occlusal surface are paid as one-surface restorations, subject to review. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.
24. Glass ionomer restorations are not covered benefits.
25. Gold foil restorations are not covered benefits.
26. Cast crowns with resin facings are not covered benefits.

Benefits and Limitations for Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable generally 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 members 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. The placement of a post is not a covered benefit when provided as an independent procedure. Posts are eligible only when provided as part of a crown buildup or implant and are considered integral to the buildup or implant.

7. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
8. Placement of a final restoration following endodontic therapy is eligible as a separate procedure.
9. An indirect pulp cap is payable only by report with radiographs documenting a near exposure of the pulp and when the final restoration is not completed for at least 60 days. An indirect pulp cap is included in the fee for the restoration when the restoration is placed in less than 60 days.
10. An indirect pulp cap is only payable once per tooth by the same dentist.
11. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist or group practice is to be included in the fee for the root canal therapy.
12. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.
13. Endodontic procedures in conjunction with overdentures are not covered benefits.
14. Retreatment of apical surgery or root canal therapy by the same dentist or group practice within 24 months, is considered part of the original procedure.
15. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.
16. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a dentist not completing the endodontic therapy.
17. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.
18. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.
19. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed on the same day or within 30 days/same tooth/same dentist/same office as root canal therapy or codes D3351-D3353.

Benefits and Limitations for Periodontic Services

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.
2. 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.
3. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, onlays, crown buildups, posts and cores or basic restorations are considered integral to the restoration.
4. Surgical periodontal procedures in the same area of the mouth within 36 months of a gingival flap procedure are not covered.
5. 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.
6. 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.
7. 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.
8. Osseous surgery is not covered when provided within 36 months of osseous surgery in the same area of the mouth.
9. 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.
10. 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.

11. One crown lengthening per tooth, per lifetime, is covered.
12. 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 is not covered. Up to four different quadrants of root planing are payable in a 24-month period and no more than two quadrants of scaling and root planing are allowed on the same date of service.
13. 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.
14. Up to four periodontal maintenance procedures and up to two routine prophylaxes may be paid within a 12-consecutive-month period to the day, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a calendar year.
15. Periodontal maintenance is only covered when performed following active periodontal treatment.
16. 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.
17. 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.
18. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.
19. Full-mouth debridement to enable comprehensive evaluation and diagnosis (code D4355) is covered once per lifetime.
20. Payment for the collection and application of an autologous blood concentrate product (D7921) is limited to once in a 36-month period.
21. Up to two tissue grafts are payable per quadrant per visit. Additional tissue grafts performed in a quadrant are not covered benefits.

Benefits and Limitations for Oral Surgery Services

1. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
2. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.
3. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are considered integral to the fee for reimplantation and/or stabilization.
4. Routine postoperative care such as suture removal is considered integral to the fee for the surgery.
5. The removal of impacted teeth is paid based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, payment will be based on the allowance for the lesser level.
6. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the contractor.
7. Unsuccessful extractions are not covered.
8. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.
9. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.
10. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.
11. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.
12. The fee for an alveoloplasty performed by the same dentist/dental office in the same surgical area on the same date of service as extractions (D7140, D7210-D7250) is disallowed.

Benefits and Limitations for Prosthodontic Services

1. When natural teeth are missing, including congenitally missing teeth, or have been extracted prior to the Effective Date of Coverage, services or treatment for the provision of an initial prosthodontic appliance (i.e. fixed bridge, implants, removable partial and/or complete dentures) is not eligible for coverage.
2. Replacement of removable and/or fixed prostheses (i.e. partial and/or complete denture, fixed bridge) are covered when the existing removable and/or fixed prostheses was provided at least five years prior to the replacement. The month and year of the initial placement of the prostheses is required for coverage and claims payment. If the existing removable and/or fixed prostheses cannot be repaired, satisfactory evidence (narrative, radiographic images) is required for coverage of the replacement prostheses.
3. 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.
4. 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.
5. Removable cast base partial dentures for members under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the contractor.
6. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a relining/rebase.
7. Recementation of 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.
8. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are integral to the denture or implant.
9. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.
10. A relining/rebase is covered once in any 36 months.
11. 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 and is approved by the contractor.
12. 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 member's responsibility.
13. 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.
14. Cast unilateral removable partial dentures are not covered benefits.
15. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
16. Temporary fixed partial dentures are not a covered benefit and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.
17. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three unit fixed partial denture.
18. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.
19. Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the cancellation date of coverage are not eligible for payment.
20. Implants are not covered when placed for a removable denture.
21. 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.
22. Replacement of implant prosthesis is covered only if the existing prosthesis were placed at least five years prior to the replacement and satisfactory evidence is presented that demonstrates they are not, and cannot be made, serviceable.
23. Repair of an implant supported prosthesis (D6090) and repair of an implant abutment (D6095) are only payable by report upon

Contractor Dentist Advisor review. The report should describe the problem and how it was repaired.

Policies, Limitations and Exclusions for Orthodontic Services

1. Payment for diagnostic services performed in conjunction with orthodontics is applied to the member's annual maximum, except as identified in the note under the "Diagnostic Services" section.
2. Orthodontic consultations will be processed as comprehensive or periodic evaluations and are subject to the same time limitations. See "Diagnostic Services" for more information.
3. Orthodontic treatment is available for dependent children up to, but not including, 19 years of age.
4. Initial payment for orthodontic services will not be made until a banding date has been submitted to the Contractor.
5. All retention and case-finishing procedures are integral to the total case fee. Observations and adjustments are integral to the payment for retention appliances.
6. Repair of damaged orthodontic appliances is not covered.
7. 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 not covered. However, recementation by a different dentist will be considered for payment as palliative emergency treatment.
8. The replacement of a lost or missing appliance is not a covered benefit.
9. Myofunctional therapy is integral to orthodontic treatment and is not payable as a separate benefit.
10. 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.
11. Periodic orthodontic treatment visits (as part of contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service.
12. It is the dentist's and the member's responsibility to notify the carrier if orthodontic treatment is discontinued or completed sooner than anticipated.

Benefits and Limitations for General Services

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered 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.
4. Deep sedation/general anesthesia and intravenous conscious sedation submitted without a report will be denied as a non-covered benefit.
5. For palliative (emergency) treatment to be covered, it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention.
6. In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the member's problem. If the only service provided is to evaluate the patient and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.
7. Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.
8. Consultations reported for a non-covered benefit, such as temporomandibular joint dysfunction (TMJD), are not covered.
9. 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.
10. 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.
11. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.

12. 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.
13. Athletic mouth guards are limited to one per 12-consecutive-month period.
14. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative endodontic x-ray is required for consideration if the endodontic therapy has not been submitted to the Contractor for payment.
15. Internal bleaching of discolored teeth (D9974) is eligible once per tooth per three-year period. External bleaching of discolored teeth may be a covered benefit.

Adjunctive Services

1. Adjunctive dental care is dental care that is:
 - a. Medically necessary in the treatment of an otherwise covered medical (not dental) condition.
 - b. An integral part of the treatment of such medical condition.
 - c. Essential to the control of the primary medical condition.
 - d. Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).
2. The Federal Dental Program does not cover adjunctive dental care services. These are medical services that may be covered under the FEHB medical policy even when provided by a general dentist or oral surgeon. The following diagnoses or conditions may fall under this category:
 - a. Treatment for relief of Myofascial Pain Dysfunction Syndrome or Temporomandibular Joint Dysfunction (TMD).
 - b. Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
 - c. Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventive procedure under this plan.
 - d. Total or complete ankyloglossia.
 - e. Intraoral abscesses which extend beyond the dental alveolus.
 - f. Extraoral abscesses.
 - g. Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.
 - h. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
 - i. Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.

General Exclusions

The exclusions listed here apply to all benefits under both the High and Standard Options. Although a specific service may be listed as a benefit, it is payable only if it determined to be necessary for the prevention, diagnosis, care or treatment of a covered condition.

- Services and treatment 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, we 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;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;

- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- 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;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- 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 restoration for misalignment of teeth;
- Gold foil restorations;
- 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;
- 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;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic services provided to a dependent of an enrolled member who has not met the 12 month waiting period requirement;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center;
- Orthodontic care for a member or spouse;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Delta Dental's Federal Employees Dental Program.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by this plan.
- All out-of-network services are subject to the usual and customary maximum allowable fee charges as defined by Delta Dental's Federal Employees Dental Program. The member is responsible for all remaining charges that exceed the allowable maximum.

Veterans Affairs

Dental Insurance Program

Under the direction of the Department of Veterans Affairs, the Caregivers and Veterans Omnibus Health Service Act of 2010 established a new dental program for both veterans enrolled in the VA healthcare and survivors or dependents of a veteran who is eligible for medical care under the VA's Civilian Health and Medical Program (CHAMPVA). There are an estimated 7.4 million individuals who are eligible for this new dental program.

Delta Dental is one of two carriers for the Veterans Affairs Dental Insurance Program (VADIP), which began as a pilot program on January 1, 2014. This voluntary program is administered and underwritten by Delta Dental of California through its subsidiary, Delta Dental Insurance Company.

Delta Dental provides three tiers of plans for the enrollee to select: Standard, Enhanced and Comprehensive.

Veterans or CHAMPVA subscribers enrolled in any VADIP plan pay 100% of the premium, with no government funding. Enrollment in VADIP is ongoing. Once eligibility is verified, coverage will be effective the first of the following month. Those who enroll in VADIP must satisfy a 12-month commitment, after which they may continue coverage on a month-to-month basis.

Delta Dental is offering VADIP as a preferred provider option (PPO) program, with access to the expansive national Delta Dental PPO dentist network (DPO in Texas).

The network service area for VADIP is the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands. Coverage under VADIP is not offered in areas outside of the service area described above. (NOTE: For the states of South Dakota and Wyoming as well as Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, the Delta Dental Premier network is also considered "in network" for VADIP enrollees).

*Applicable to Enhanced and Comprehensive Plans only

Plan Summary of Coverage

Delta Dental offers three VADIP plans, all of which offer 100% coverage for in-network cleanings, exams and an x-ray. Once you choose your plan, use the Find a Dentist tool on our website. It's easy to check if your current dentist is in our network or search your local area for one who is. When you visit a dentist in the Delta Dental VADIP network, you'll save more with the lowest out-of-pocket costs.

	Enhanced Plan				Comprehensive Plan				Prime Plan			
	In-Network		Out-of-Network		In-Network		Out-of-Network		In-Network		Out-of-Network	
	Year 1	Year 2+	Year 1	Year 2+	Year 1	Year 2+	Year 1	Year 2+	Year 1	Year 2+	Year 1	Year 2+
Diagnostic and Preventive¹	100%	100%	80%	80%	100%	100%	80%	80%	100%	100%	90%	90%
Basic Restorative	50%	50%	30%	30%	60%	60%	40%	40%	70%	70%	60%	60%
Major Restorative²	NAB	NAB	NAB	NAB	NAB	50%	NAB	30%	NAB	70%	NAB	60%
Endodontics²	NAB	50%	NAB	30%	NAB	50%	NAB	30%	NAB	50%	NAB	40%
Periodontics²	NAB	50%	NAB	30%	NAB	50%	NAB	30%	NAB	50%	NAB	40%
Oral Surgery^{2,3}	50%	50%	30%	30%	50%	50%	30%	30%	50%	50%	40%	40%
Prosthodontics²	NAB	NAB	NAB	NAB	NAB	50%	NAB	30%	NAB	50%	NAB	40%
General Services	NAB	NAB	NAB	NAB	50%	50%	30%	30%	50%	50%	40%	40%
Orthodontics	NAB	NAB	NAB	NAB	NAB	NAB	NAB	NAB	NAB	NAB	NAB	NAB
Deductible	\$50	\$50	\$50	\$50	\$0	\$0	\$50	\$50	\$0	\$0	\$50	\$50
Annual Maximum	\$1000	\$1000	\$1000	\$1000	\$1500	\$1500	\$1500	\$1500	\$3000	\$3000	\$3000	\$3000

NAB = Not a Benefit

¹ The deductible is waived for diagnostic and preventive procedures for all plans.

² The waiting period is 12 months for major restorative (Comprehensive and Prime; Enhanced not covered), endodontics (all plans), periodontics (all plans), oral surgery³ (all plans) and prosthodontics (Comprehensive and Prime; Enhanced not covered).

³ Simple extractions (procedure codes D7111 and D7140) are the only covered oral surgery services under the Enhanced Plan and the only covered oral surgery services in the first 12 months under the Comprehensive and Prime plans.

Enhanced Plan – Policies, Covered Benefits, Limitations and Exclusions

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
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

Policy Limitations for Diagnostic Services

- 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.
- Only one (1) comprehensive evaluation (D0150) will be allowed in a calendar year.
- 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.
- Re-evaluations are considered integral to the originally performed procedures.

- Payment for more than one of any category of full-mouth radiographs 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 films.
- A panoramic radiograph taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitation. Payment for panoramic radiographs is limited to one within a 48-month period.

Preventive Services

D1110	Prophylaxis—adult
D1120	Prophylaxis—child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride - excluding varnish
D1351	Sealant—per tooth
D1510	Space maintainer—fixed—unilateral
D1516	Space maintainer—fixed - bilateral, maxillary
D1517	Space maintainer—fixed—bilateral, mandibular
D1520	Space maintainer—removable—unilateral
D1526	space maintainer - removable - bilateral, maxillary
D1527	space maintainer - removable - bilateral, mandibular
D1550	Re-cement or re-bond space maintainer
D1575	Distal shoe space maintainer—fixed—unilateral

Policy Limitations for Preventive Services

- Two routine prophylaxes are covered in a calendar year.
- 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.
- Routine prophylaxes are considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, 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.
7. Space maintainers are only covered for dependent children under the age of 19.
8. Sealants are covered on permanent molars through age 18. 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 restoration of the occlusal surface are considered integral procedures.
11. Distal shoe space maintainer is a benefit to guide the eruption of the first permanent molar.

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

Policy Limitations for Basic Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration 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 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, dentinal 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 patient, per tooth, per lifetime.

10. The charge for a crown 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.
11. Crowns 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 crown.
12. Recementation of prefabricated and cast crowns, onlays, and inlays is eligible once per six month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
13. 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.

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 junction 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
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.)
D3410	Apicoectomy anterior
D3421	Apicoectomy—premolar (first root)
D3425	Apicoectomy—molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling—per root
D3450	Root amputation—per root
D3920	Hemisection (including any root removal), not including root canal therapy

Policy Limitations for Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members 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 a separate procedure, payable based on plan coverage.

Comprehensive Plan – Policies, Covered Benefits, Limitations and Exclusions

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

Policy Limitations for Diagnostic 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. Payment for more than one of any category of full-mouth radiographs 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 films.
6. A panoramic radiograph taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitation. Payment for panoramic radiographs is limited to one within a 48-month period.

Preventive Services

D1110	Prophylaxis—adult
D1120	Prophylaxis—child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride—excluding varnish
D1351	Sealant—per tooth
D1510	Space maintainer—fixed—unilateral
D1516	Space maintainer—fixed—bilateral, maxillary
D1516	space maintainer—fixed—bilateral, mandibular
D1527	Space maintainer—removable—bilateral, mandibular
D1520	Space maintainer—removable—unilateral
D1526	space maintainer—removable—bilateral, maxillary
D1527	space maintainer—removable—bilateral, mandibular

D1550	Re-cement or re-bond space maintainer
D1575	Distal shoe space maintainer—fixed—unilateral

Policy Limitations for Preventive Services

- Two routine prophylaxes are covered in a calendar year.
- 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.
- Routine prophylaxes are considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomies or gingivoplasties, gingival flap procedures, mucogingival surgery, or osseous surgery.
- Routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.
- 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
- Two topical fluoride applications are covered in a calendar year.
- Space maintainers are only covered for dependent children under the age of 19.
- Sealants are covered on permanent molars through age 18. 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.
- Sealants for teeth other than permanent molars are not covered.
- Sealants provided on the same date of service and on the same tooth as a restoration of the occlusal surface are considered integral procedures.
- Distal shoe space maintainer is a benefit to guide the eruption of the first permanent molar.

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

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
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
D2780	Crown— 3/4 cast high noble metal
D2781	Crown— 3/4 cast predominantly base metal
D2782	Crown— 3/4 cast noble metal
D2783	Crown— 3/4 porcelain/ceramic
D2790	Crown—full-cast high noble metal

D2791	Crown—full-cast predominantly base metal
D2792	Crown—full-cast high noble metal
D2794	Crown—titanium
D2954	Prefabricated post and core in addition to crown
D2980	Crown repair necessitated by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2983	Veneer repair necessitated by restorative material failure

Policy Limitations for Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration 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 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, dentinal 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 patient, per tooth, per lifetime.
10. The charge for a crown or 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.
11. Onlays, permanent single crown restorations, and posts and cores for members 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.).
12. 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.
13. Cast posts and cores (D2952) are processed as an alternate 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 by for the prefabricated post and core.
14. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, 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, onlay, buildup, or post and core is not and cannot be made serviceable. Satisfactory evidence must show that the existing crown, 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.
15. 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 onlay, crown, or post and core.
16. 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.

17. Recementation of prefabricated and 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.
18. 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.
19. 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.

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 junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis—permanent tooth with incomplete root
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
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.)
D3410	Apicoectomy—anterior
D3421	Apicoectomy—premolar (first root)
D3425	Apicoectomy/periradicular surgery—molar (first root)
D3426	Apicoectomy (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling—per root
D3450	Root amputation—per root
D3920	Hemisection (including any root removal), not including root canal therapy

Policy Limitations for Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only.
3. 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.
4. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members 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.
5. Treatment of a root canal obstruction is considered an integral procedure. 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, payable based on plan coverage.

Periodontic Services

D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-
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	bounded spaces per quadrant		
D4211	Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant	D4341	Periodontal scaling and root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	D4342	Periodontal scaling and root planing—one to three teeth, per quadrant
D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant	D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant	D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit.
D4249	Clinical crown lengthening—hard tissue	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4260	Osseous surgery (including elevation of a full thickness flap and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant	D4910	Periodontal maintenance
D4261	Osseous surgery (including elevation of a full thickness flap and closure)—one to three contiguous teeth or tooth-bounded spaces per quadrant		
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 same graft site		
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		

Policy Limitations for Periodontic 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, onlays, crown buildups, posts and cores or basic restorations are considered integral to the restoration.
3. Surgical periodontal procedures or scaling and root planing 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 is not covered. Up to four different quadrants of root planing are payable in a 24-month period and no more than two quadrants of scaling and root planing are allowed on the same date of service.
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 or scaling in presence of generalized moderate or severe gingival inflammation and up to two routine prophylaxes may be paid within a 12-consecutive-month period to the day, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a calendar year.
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 (code D4355) is covered once per lifetime.
19. Up to two tissue grafts are payable per quadrant per visit. Additional tissue grafts performed in a quadrant are not covered benefits.

Prosthodontic Services

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 conventional clasps, rests and teeth)
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5221	Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
D5222	Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
D5223	Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224	Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5282	Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary
D5283	Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular
D5410	Adjust complete denture—maxillary
D5411	Adjust complete denture—mandibular
D5421	Adjust partial denture—maxillary
D5422	Adjust partial denture—mandibular

Veterans Affairs

Dental Insurance Program

D5511	Repair broken complete denture base, mandibular		abutment supported
D5512	Repair broken complete denture base, maxillary	D6056	Prefabricated abutment—includes modification and placement
D5520	Replace missing or broken teeth—complete denture (each tooth)	D6057	Custom fabricated abutment—includes placement
D5611	Repair resin partial denture base, mandibular	D6058	Abutment supported porcelain/ceramic crown
D5612	Repair resin partial denture base, maxillary	D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D5621	Repair cast partial framework, mandibular	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D5622	Repair cast partial framework, maxillary	D6061	Abutment supported porcelain fused to metal crown (noble metal)
D5630	Repair or replace broken retentive/ clasping materials - per tooth	D6062	Abutment supported cast metal crown (high noble metal)
D5640	Replace broken teeth—per tooth	D6063	Abutment supported cast metal crown (predominantly base metal)
D5650	Add tooth to existing partial denture	D6064	Abutment supported cast metal crown (noble metal)
D5660	Add clasp to existing partial denture—per tooth	D6065	Implant supported porcelain/ceramic crown
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D5710	Rebase complete maxillary denture	D6068	Abutment supported retainer for porcelain/ceramic FPD
D5711	Rebase complete mandibular denture	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D5720	Rebase maxillary partial denture	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D5721	Rebase mandibular partial denture	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D5730	Reline complete maxillary denture (chairside)	D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D5731	Reline complete mandibular denture (chairside)	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D5740	Reline maxillary partial denture (chairside)	D6074	Abutment supported retainer for cast metal FPD (noble metal)
D5741	Reline mandibular partial denture (chairside)	D6075	Implant supported retainer for ceramic FPD
D5750	Reline complete maxillary denture (laboratory)	D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D5751	Reline complete mandibular denture (laboratory)	D6077	Implant supported retainer for cast
D5760	Reline maxillary partial denture (laboratory)		
D5761	Reline mandibular partial denture (laboratory)		
D5850	Tissue conditioning, maxillary		
D5851	Tissue conditioning, mandibular		
D6010	Surgical placement of implant body: endosteal implant		
D6013	Surgical placement of mini-implant		
D6055	Connecting bar—implant supported or		

	metal FPD (titanium, titanium alloy, or high noble metal)	D6241	Pontic—porcelain fused to predominantly base metal
D6080	Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prostheses and abutments	D6242	Pontic—porcelain fused to noble metal
D6090	Repair implant supported prosthesis by report	D6245	Pontic—porcelain/ceramic
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	D6545	Retainer—cast metal for resin bonded fixed prosthesis
D6094	Abutment supported crown (titanium)	D6548	Retainer—porcelain/ceramic for resin-bonded fixed prosthesis
D6096	Remove broken implant retaining screw	D6549	Resin retainer—for resin bonded fixed prosthesis
D6100	Implant removal, by report	D6600	Retainer inlay—porcelain/ceramic, two surfaces
D6092	Re-cement or re-bond implant/abutment supported crown	D6601	Retainer inlay—porcelain/ceramic, three or more surfaces
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	D6604	Retainer inlay—cast predominantly base metal, two surfaces
D6110	Implant/abutment supported removable denture for edentulous arch—maxillary	D6605	Retainer inlay—cast predominantly base metal, three or more surfaces
D6111	Implant/abutment supported removable denture for edentulous arch—mandibular	D6608	Retainer onlay—porcelain/ceramic, two surfaces
D6112	Implant/abutment supported removable denture for partially edentulous arch—maxillary	D6609	Retainer onlay—porcelain/ceramic, three or more surfaces
D6113	Implant/abutment supported removable denture for partially edentulous arch—mandibular	D6612	Retainer onlay—cast predominantly base metal, two surfaces
D6114	Implant/abutment supported fixed denture for edentulous arch—maxillary	D6613	Retainer onlay—cast predominantly base metal, three or more surfaces
D6115	Implant/abutment supported fixed denture for edentulous arch—mandibular	D6740	Retainer crown—porcelain/ceramic
D6116	Implant/abutment supported fixed denture for partially edentulous arch—maxillary	D6750	Retainer crown—porcelain fused to predominantly base metal
D6117	Implant/abutment supported fixed denture for partially edentulous arch—mandibular	D6751	Retainer crown—porcelain fused to high noble metal
D6194	Abutment supported retainer crown for FPD(titanium)	D6752	Retainer crown—porcelain fused to noble metal
D6210	Pontic—cast high noble metal	D6780	Retainer crown— 3/4 cast high noble metal
D6211	Pontic—cast predominantly base metal	D6781	Retainer crown— 3/4 cast predominantly base metal
D6212	Pontic—cast noble metal	D6782	Retainer crown— 3/4 cast noble metal
D6214	Pontic—titanium	D6783	Retainer crown— 3/4 porcelain/ceramic
D6240	Pontic—porcelain fused to high noble metal	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
		D6930	Re-cement or re-bond fixed partial denture

D6980 Fixed partial denture repair necessitated by restorative material failure

Policy Limitations for Prosthodontic Services

1. Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to Effective Date of Coverage may not be eligible for coverage.
2. 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.
3. 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.
4. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.
5. Recementation of 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.
6. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are integral to the denture or implant.
7. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.
8. A reline/rebase is covered once in any 36 months.
9. 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.
10. 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 member's responsibility.
11. 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.

12. Cast unilateral removable partial dentures are not covered benefits.
13. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
14. Temporary fixed partial dentures are not a covered benefit and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.
15. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three unit fixed partial denture.
16. Replacement of removable prostheses and fixed prostheses is covered only if the existing removable and/or fixed prostheses was 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. Satisfactory evidence must show that the existing removable prostheses 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.
17. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.
18. Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the cancellation date of coverage are not eligible for payment.

Oral Surgery Services

- D7111** Extraction, coronal remnants—primary tooth
- D7140** Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Policy Limitations for Oral Surgery Services

1. Routine postoperative care such as suture removal is considered integral to the fee for the oral surgery services.

Exclusions

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.

Veterans Affairs

Dental Insurance Program

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, Delta Dental 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.
4. Those submitted by a dentist which is for the same services performed on the same date for the same member 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 member 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 member 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 member's effective coverage date.
12. Those incurred after the termination date of the member'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. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
18. Those resulting from the patient's failure to comply with professionally prescribed treatment.
19. Telephone consultations.
20. Any charges for failure to keep a scheduled appointment.
21. Duplicate and temporary devices, appliances, and services.
22. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
23. Plaque control programs, oral hygiene instruction, and dietary instructions.
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 restoration 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 members' records, charts or x-rays, or any costs associated with forwarding/mailing copies of members' records, charts or x-rays.
34. Nitrous oxide.
35. Oral sedation.
36. State or territorial taxes on dental services performed.

General Services

D9110	Palliative (emergency) treatment of dental pain—minor procedure
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— <u>each subsequent 15 minute increment</u>
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
D9944	Occlusal guard—hard appliance, full arch
D9945	Occlusal guard—soft appliance, full arch
D9946	Occlusal guard—hard appliance, partial arch
D9941	Fabrication of athletic mouth guard
D9999	Unspecified adjunctive procedure, by report

Policy Limitations for General Services

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered 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.
5. For palliative (emergency) treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention.
6. In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the member's problem. If the only service provided is to evaluate the patient and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.
7. Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.
8. Consultations reported for a non-covered benefit, such as Temporomandibular Joint Dysfunction (TMJD), are not covered.
9. 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.
10. 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.
11. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.
12. 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.

Veterans Affairs

Dental Insurance Program

13. Athletic mouth guards are limited to one per 12-consecutive-month period.
14. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative endodontic x-ray is required for consideration if the endodontic therapy has not been submitted to the Contractor for payment.
15. Internal bleaching of discolored teeth (D9974) is eligible once per tooth per three-year period.

Exclusions

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, Delta Dental 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.
4. Those submitted by a dentist which is for the same services performed on the same date for the same member 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 member 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 member 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 member's effective coverage date.
12. Those incurred after the termination date of the member'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. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
18. Those resulting from the patient's failure to comply with professionally prescribed treatment.
19. Telephone consultations.
20. Any charges for failure to keep a scheduled appointment.
21. Duplicate and temporary devices, appliances, and services.
22. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
23. Plaque control programs, oral hygiene instruction, and dietary instructions.
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 restoration 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 members' records, charts or x-rays, or any costs associated with forwarding/mailing copies of members' records, charts or x-rays.
34. Nitrous oxide.
35. Oral sedation.
36. State or territorial taxes on dental services performed.

Prime Plan – Policies, Covered Benefits, Limitations and Exclusions

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

Policy Limitations for Diagnostic 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. Payment for more than one of any category of full-mouth radiographs 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 films.
6. A panoramic radiograph taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitation. Payment for panoramic radiographs is limited to one within a 48-month period.

Preventive Services

D1110	Prophylaxis—adult
D1120	Prophylaxis—child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride—excluding varnish
D1351	Sealant—per tooth
D1510	Space maintainer—fixed—unilateral
D1516	Space maintainer—fixed—bilateral, maxillary
D1517	Space maintainer—fixed—bilateral, mandibular

D1520	Space maintainer—removable—unilateral
D1526	Space maintainer—removable—bilateral, maxillary
D1527	Space maintainer—removable—bilateral, mandibular
D1550	Re-cement or re-bond space maintainer
D1575	Distal shoe space maintainer—fixed—unilateral

Policy Limitations for Preventive Services

1. Two routine prophylaxes are covered in a calendar year.
2. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance procedures.
3. Routine prophylaxes are considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planing, periodontal maintenance, gingivectomies or gingivoplasties, gingival flap procedures, mucogingival surgery or osseous surgery.
4. Two topical fluoride applications are covered in a calendar year.
5. Space maintainers are only covered for dependent children under the age of 19.
6. Sealants are covered on permanent molars through age 18. 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.
7. Sealants for teeth other than permanent molars are not covered.
8. Sealants provided on the same date of service and on the same tooth as a restoration of the occlusal surface are considered integral procedures.
9. Distal shoe space maintainer is a benefit to guide the eruption of the first permanent molar.

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
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

Policy Limitations for Basic Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration 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 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, dentinal 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 patient, per tooth, per lifetime.
10. The charge for a crown should include all charges for work related to its placement to include, but not limited to, preparation of gingival tissue, tooth preparation, diagnostic casts (study models), impressions, try-in visits, and cementation of a permanent crowns.
11. Onlays, permanent single crown restorations, and posts and cores for enrollees 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.).
12. 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.
13. Cast posts and cores (D2952) are processed as an alternate 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.
14. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement. Satisfactory evidence must show that the existing crown, 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.
15. 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 onlay, crown, or post and core.

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

Policy Limitations for Basic Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).

5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration 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 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, dentinal 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 patient, per tooth, per lifetime.
10. The charge for a crown 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.
11. Crowns 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 crown.
12. Recementation of prefabricated and cast crowns, onlays, and inlays is eligible once per six month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
13. 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.

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 junction 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
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.)
D3410	Apicoectomy anterior
D3421	Apicoectomy—premolar (first root)
D3425	Apicoectomy—molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling—per root
D3450	Root amputation—per root

D3920 Hemisection (including any root removal), not including root canal therapy

Policy Limitations for Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members 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 a separate procedure, payable based on plan coverage.

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

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

D4346 Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation

- D4355** Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit.
- D4381** Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
- D4910** Periodontal maintenance

Policy Limitations for Periodontic 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, 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 is not covered. Up to four different quadrants of root planing are payable in a 24-month period and no more than two quadrants of scaling and root planing are allowed on the same date of service.
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 or scaling in presence of generalized moderate or severe gingival inflammation and up to two routine prophylaxes may be paid within a calendar year, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a calendar year.
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 (code D4355) is covered once per lifetime.
19. Up to two tissue grafts are payable per quadrant per visit. Additional tissue grafts performed in a quadrant are not covered benefits.

Oral Surgery Services

D7111	Extraction, coronal remnants—primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Policy Limitations for Oral Surgery Services

1. Routine postoperative care such as suture removal is considered integral to the fee for the oral surgery services.

Exclusions

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, Delta Dental 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.
4. Those submitted by a dentist which is for the same services performed on the same date for the same member 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 member 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 member 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 member's effective coverage date.
12. Those incurred after the termination date of the member'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. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
18. Those resulting from the patient's failure to comply with professionally prescribed treatment.
19. Telephone consultations.
20. Any charges for failure to keep a scheduled appointment.
21. Duplicate and temporary devices, appliances, and services.
22. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
23. Plaque control programs, oral hygiene instruction, and dietary instructions.
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 restoration 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 members' records, charts or x-rays, or any costs associated with forwarding/mailing copies of members' records, charts or x-rays.
- 34. Nitrous oxide.
- 35. Oral sedation.
- 36. State or territorial taxes on dental services performed.

Prime Plan - Additions

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
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
D2780	Crown—3/4 cast high noble metal
D2781	Crown—3/4 cast predominantly base metal
D2782	Crown—3/4 cast noble metal
D2783	Crown—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
D2950	Core buildup, including any pins when required
D2954	Prefabricated post and core in addition to crown
D2980	Crown repair necessitated by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2983	Veneer repair necessitated by restorative material failure

Policy Limitations for Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration 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 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, dentinal 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 patient, per tooth, per lifetime.
10. The charge for a crown or 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.
11. Onlays, permanent single crown restorations, and posts and cores for members 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.).
12. 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.
13. Cast posts and cores (D2952) are processed as an alternate 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.
14. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement. Satisfactory evidence must show that the existing crown, 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.
15. 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 onlay, crown, or post and core.
16. 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.

17. Recementation of prefabricated and 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.
18. 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. 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.

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 junction 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.)
- D3410** Apicoectomy—anterior
- D3421** Apicoectomy—premolar (first root)
- D3425** Apicoectomy—molar (first root)
- D3426** Apicoectomy (each additional root)
- D3427** Periradicular surgery without apicoectomy
- D3430** Retrograde filling—per root
- D3450** Root amputation—per root
- D3920** Hemisection (including any root removal), not including root canal therapy

Policy Limitations for Endodontic Services

1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members 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 a separate procedure, payable based on plan coverage.

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
- 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 soft 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
- D4346** Scaling in presence of generalized moderate or severe gingival inflammation —full mouth, after oral evaluation
- D4355** Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit
- D4381** Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
- D4910** Periodontal maintenance

Policy Limitations for Periodontal Services

1. Gingivectomy or gingivoplasty, gingival flap procedure, guided tissue regeneration, soft tissue grafts, bone replacement grafts and osseous surgery provided within 36 months of the same surgical periodontal procedure, in the same area of the mouth are not covered.
2. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, onlays, core buildups, posts and cores or basic restorations are considered integral to the restoration.
3. 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.
4. 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.
5. 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.
6. Osseous surgery is not covered when provided within 36 months of osseous surgery in the same area of the mouth.
7. 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.
8. 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.
9. One crown lengthening per tooth, per lifetime, is covered.
10. 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 is not covered. Up to four different quadrants of root planing are payable in a 24-month period and no more than two quadrants of scaling and root planing are allowed on the same date of service.
11. 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.
12. Up to four of either D4910 periodontal maintenance procedures and/or D4326 scaling in presence of generalized may be paid within a calendar year period. Or treatment may be combined with (up to two) routine prophylaxes, but the combination may not exceed four procedures in a calendar year period.
13. Periodontal maintenance is only covered when performed following active periodontal treatment.
14. 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.
15. 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.

16. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.
17. Full mouth debridement to enable comprehensive evaluation and diagnosis (code D4355) is covered once per lifetime.
18. Up to two tissue grafts are payable per quadrant per visit. Additional tissue grafts performed in a quadrant are not covered benefits.

Prosthetic Services

- 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 conventional clasps, rests and teeth)
- D5214** Mandibular partial denture—cast metal framework with resin denture bases (including conventional clasps, rests and teeth)
- D5282** Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary
- D5283** Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular
- D5221** Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
- D5222** Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
- D5223** Immediate maxillary partial denture—cast metal framework with resin denture bases

(including any conventional clasps, rests and teeth)

- D5224** Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- 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** Repair 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)
- D5671** Replace all teeth and acrylic on cast metal framework (mandibular)
- 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)

Veterans Affairs

Dental Insurance Program

D5751	Reline complete mandibular denture (laboratory)	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D5760	Reline maxillary partial denture (laboratory)	D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D5761	Reline mandibular partial denture (laboratory)	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D5850	Tissue conditioning, maxillary	D6074	Abutment supported retainer for cast metal FPD (noble metal)
D5851	Tissue conditioning, mandibular	D6075	Implant supported retainer for ceramic FPD
D6010	Surgical placement of implant body: endosteal implant	D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6013	Surgical placement of mini implant	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6055	Connecting bar - implant supported or abutment supported	D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6056	Prefabricated abutment - includes modification and placement	D6090	Repair implant supported prosthesis, by report
D6057	Custom fabricated abutment—includes placement	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/ abutment supported prosthesis, per attachment
D6058	Abutment supported porcelain/ceramic crown	D6092	Re-cement or re-bond implant/abutment supported crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	D6093	Re-cement or re-bond implant/abutment supported fixed partial denture
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	D6094	Abutment supported crown (titanium)
D6061	Abutment supported porcelain fused to metal crown (noble metal)	D6095	Repair implant abutment, by report
D6062	Abutment supported cast metal crown (high noble metal)	D6096	Remove broken implant retaining screw
D6063	Abutment supported cast metal crown (predominantly base metal)	D6100	Implant removal, by report
D6064	Abutment supported cast metal crown (noble metal)	D6110	Implant/abutment supported removable denture for edentulous arch—maxillary
D6065	Implant supported porcelain/ceramic crown	D6111	Implant/abutment supported removable denture for edentulous arch—mandibular
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	D6112	Implant/abutment supported removable denture for partially edentulous arch—maxillary
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	D6113	Implant/abutment supported removable denture for partially edentulous arch—mandibular
D6068	Abutment supported retainer for porcelain/ceramic FPD	D6114	Implant/abutment supported fixed denture for edentulous arch—maxillary
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	D6115	Implant/abutment supported fixed denture for edentulous arch—mandibular
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		

D6116	Implant/abutment supported fixed denture for partially edentulous arch—maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch—mandibular
D6194	Abutment supported retainer crown for FPD—(titanium)
D6210	Pontic—cast high noble metal
D6211	Pontic—cast predominantly base metal
D6212	Pontic—cast noble metal
D6214	Pontic—titanium
D6240	Pontic—porcelain fused to high noble metal
D6241	Pontic—porcelain fused to predominantly base metal
D6242	Pontic—porcelain fused to noble metal
D6245	Pontic—porcelain/ceramic
D6545	Retainer—cast metal for resin bonded fixed prosthesis
D6548	Retainer—porcelain/ceramic for resin bonded fixed prosthesis
D6549	Resin retainer—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
D6752	Retainer crown—porcelain fused to noble metal

D6780	Retainer crown— 3/4 cast high noble metal
D6781	Retainer crown—3/4 cast predominantly base metal
D6782	Retainer crown—3/4 cast noble metal
D6783	Retainer crown—3/4 porcelain/ceramic
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
D6930	Re-cement or re-bond fixed partial denture
D6980	Fixed partial denture repair necessitated by restorative material failure

Policy Limitations for Prosthodontic Services

1. Services or treatment for the provision of an initial prosthodontic appliance (i.e., fixed bridge restoration, implants, removable partial or complete denture, etc.) when it replaces natural teeth extracted or missing, including congenital defects, prior to Effective Date of Coverage may not be eligible for coverage.
2. 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.
3. 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.
4. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a relining/rebase.
5. Recementation of 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.
6. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are integral to the denture or implant
7. The relining or rebasing of a denture is considered integral when performed within six

- months following the insertion of that denture.
8. A reline/rebase is covered once in any 36 months.
 9. 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.
 10. 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 member's responsibility.
 11. A fixed partial denture and removable partial denture are not covered benefits in the same arch.
 12. Payment will be made for a removable partial denture to replace all missing teeth in the arch.
 13. Cast unilateral removable partial dentures are not covered benefits.
 14. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
 15. Temporary fixed partial dentures are not a covered benefit and, when done in conjunction with permanent fixed partial dentures, are considered integral to the allowance for the fixed partial dentures.
 16. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three unit fixed partial denture.
 17. Replacement of removable prostheses and fixed prostheses is covered only if the existing removable or fixed prostheses was inserted at least five years prior to the replacement replacement and satisfactory evidence is presented that the existing removable and/or fixed prostheses cannot be made serviceable. Satisfactory evidence must show that the existing removable prostheses 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.
 18. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.
 19. Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the cancellation date of coverage are not eligible for payment.

20. Implant procedures, including applicable restorations and repairs, are a covered benefit once in five years.

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 of residual tooth roots (cutting procedure)
- D7251** Coronectomy—intentional partial tooth removal
- D7270** Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- D7280** Exposure of an unerupted tooth
- 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
- D7971** Excision of pericoronal gingiva
- D7999** Unspecified oral surgery procedure, by report

Policy Limitations for Oral Surgery Services

1. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
2. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow up care is considered integral to the procedure.
3. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are considered integral to the fee for reimplantation and/or stabilization.
4. Routine postoperative care such as suture removal is considered integral to the fee for the oral surgery services.
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. The fee for an alveoloplasty performed by the same dentist/dental office in the same surgical area on the same date of service as extractions (D7140, D7210-D7250) is disallowed.

General Services

- D9110** Palliative (emergency) treatment of dental pain—minor procedure
- 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
- D9310** Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician
- D9444** Occlusal guard - hard appliance, full arch
- D9445** Occlusal guard - soft appliance, full arch
- D9446** Occlusal guard - hard appliance, partial arch
- 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
- D9940** Occlusal guard, by report
- D9941** Fabrication of athletic mouth guard
- D9999** Unspecified adjunctive procedure, by report

Policy Limitations for General Services

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered 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.
5. For palliative (emergency) treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention.
6. In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the member's problem. If the only service provided is to evaluate the patient and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.
7. Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.
8. Consultations reported for a non-covered benefit, such as temporomandibular joint dysfunction (TMJD), are not covered.
9. 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.

10. 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.
11. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.
12. 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.
13. Athletic mouth guards are limited to one in a 12 month period.

Exclusions

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, Delta Dental 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.
4. Those submitted by a dentist which is for the same services performed on the same date for the same member 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 member 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.
9. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
10. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
11. 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.
12. Those performed prior to the member's effective coverage date.
13. Those incurred after the termination date of the member's coverage unless otherwise indicated.
14. 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.)
15. Those not meeting accepted standards of dental practice.
16. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for enrollees.
18. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
19. Those performed by a dentist who is compensated by a facility for similar covered services performed for enrollees.
20. Those resulting from the patient's failure to comply with professionally prescribed treatment.
21. Telephone consultations.
22. Any charges for failure to keep a scheduled appointment.
23. Duplicate and temporary devices, appliances, and services.
- 24.

25. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
26. Plaque control programs, oral hygiene instruction, and dietary instructions.
27. 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 restoration for misalignment of teeth.
28. Gold foil restorations.
29. 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.
30. 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.
31. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
32. 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.
33. Office infection control charges.
34. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
35. Adjunctive dental services as defined by applicable federal regulations.
36. Charges for copies of members' records, charts or x-rays, or any costs associated with forwarding/ mailing copies of members' records, charts or x-rays.
37. Nitrous oxide.
38. Oral sedation.
39. State or territorial taxes on dental services performed.

Public Health Service Active Duty Dental Insurance Program

The Public Health Service Active Duty Dental Program (PHS ADDP) is a federally funded dental program for the active duty officers of the Commissioned Corps of the U. S. Public Health Service. Commissioned Corps officers are highly trained public health professionals who work in one of several fields, including medicine, dentistry, pharmaceutical and veterinary medicine as well as environmental, dietary and therapy health services. Family members of these officers are not included under this program.

Coverage under the PHS ADDP has been determined by the U.S. Public Health Service (USPHS) and is based on PHS policies and regulations. Enrollees in the PHS ADDP enrollees have no waiting periods to satisfy, no deductibles and no annual maximum.

The program has a broad scope of coverage that encompasses a wide range of the most commonly needed and used dental services, including most diagnostic, preventive, basic and major restorative, periodontic, endodontic, oral surgery, prosthetic and emergency services. Dental services that are excluded from coverage under the program include orthodontics and/or orthognathic surgery, inlays and cosmetic dentistry, and services related to developmental growth deformities.

Coverage under the PHS ADDP is offered worldwide, with the Delta Dental Premier dentist network available to those residing in the 50 United States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

Covered services are paid by Delta Dental at 100% directly to the dentist whether the treating dentist is in the Delta Dental Premier network or is an out-of-network dentist. When services are provided overseas, Delta Dental will pay the enrollee directly.

Office of the Comptroller of the Currency

Dental Insurance Program

Effective January 1, 2015, Delta Dental of California's Federal Government Programs division began administering dental benefits under the Office of the Comptroller of the 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 this program are a spouse or domestic partner, unmarried children up to age 22 and/or unmarried children up to age 25 who are full-time students in an accredited institution of learning and who meet certification requirements.

The OCC Dental Insurance Program provides two available options from which to choose - a PPO (preferred provider organization) option and a DHMO (dental health maintenance organization) option. Full-time or part-time employees of the OCC and OFR are eligible to enroll in the OCC Dental Insurance Program. Employees who retire from the OCC or who separate from the OCC on a disability retirement are eligible to continue their participation in the program. OFR employees who retire are not eligible to continue their participation in the program.

The dental office can contact Delta Dental's Customer Service department at 844-883-4288 for questions regarding benefits, eligible or claims for the OCC Dental Insurance Program.

PPO Option

The PPO option provides both in-network and out-of-network benefits. Under this option, enrollees are required to pay coinsurance for services rendered by their dentist. Reimbursement levels for treatment provided by an in-network dentist are based on reduced contracted fees. For services provided by an out-of-network dentist, Delta Dental will pay based upon usual and customary charges.

Benefits under the plan are limited to a calendar year maximum and a lifetime orthodontic maximum. Enrollees 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.

OCC Dental Insurance Program enrollees now have the option to use an assigned Alternative Identifier (Alt ID) instead of their Social Security number (SSN) when obtaining dental services under their PPO plan. Dentists can use either the patient's Alt ID or SSN when submitting claims to Delta Dental.

Delta Dental PPO™ Option Coverage

On the following page is a summary of the benefits under the PPO option.

Summary of PPO Option Coverage

Benefits	In-Network		Out-of-Network	
	Plan Pays	Enrollee Pays	Plan Pays	Enrollee Pays
Class I: Diagnostic, Preventive and Emergency Care <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) care to relieve pain 	100%	0%	100%	0%
Class II: Basic Restorative Care, Endodontics, Periodontics, Prosthodontics, Oral Surgery and Anesthesia <ul style="list-style-type: none"> Fillings Root canal therapy Osseous surgery, periodontal scaling and root planing Dental adjustments and repairs Extractions Anesthesia (deep sedation/general, IV moderate (conscious) sedation) 	80% ¹	20% ¹	80% ¹	20% ¹
Class III³: Major Restorative Care, Implants and Prosthodontics <ul style="list-style-type: none"> Crowns, inlays, and onlays Surgical Implants, implant crowns Dentures, bridges and partials 	60% ¹	40% ¹	60% ¹	40% ¹
Class IV: Orthodontia <ul style="list-style-type: none"> Coverage for children and adults 	60% ¹	40% ¹	60% ¹	40% ¹
Authorization for specialty care	Preauthorization is not required			
Calendar Year Maximum (January 1 - December 31) Class I, II and III expenses	\$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			

¹ Subject to annual deductible

² Non-Delta Dental, non-contracted dentists (out-of-network dentists) are paid based on usual and customary charges.

³ 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 plans pays 30% and the enrollee pays 70%. For 25 months and beyond, the plans pays 60% and the enrollee pays 40%.

PPO Option Covered Services

Procedures that are covered under the Delta Dental PPO option for the OCC Dental Insurance Program are listed in this section. For further clarification, some services that are not covered are listed as exclusions. Please refer to the “Non-Covered Services (Exclusions)” at the end of this section.

Some Delta Dental PPO option benefits are subject to time limitations that specify how often the benefit can be paid. Time limitations indicated pertain to the period of time immediately preceding the date of the service being billed. This period is not affected by a calendar year, benefit year or enrollment year. For more detailed information regarding time limitations for the covered services listed below, please refer to the policy limitations for each of the covered services listings in the “PPO Option Policy Limitations by Service Category” section.

Covered services for the OCC Dental Insurance Program are determined by the OCC and are based upon generally accepted dental practice standards. All covered services listed in this section conform to the current version of the American Dental Association (ADA) Current Dental Terminology.

% Paid In-Network:

- 100% for Diagnostic & Preventive Services
- 80% for Basic Restorative Services
- 60% for Major Restorative, Endodontic, Periodontic, Oral Surgery, Prosthodontic & Orthodontic Services

% Paid Out-of-Network:

- 100% for Diagnostic & Preventive Services
- 80% for Basic Restorative Services
- 60% for Major Restorative, Endodontic, Periodontic, Oral Surgery, Prosthodontic & Orthodontic Services

Annual Maximum:

\$2,500

Annual Deductible:

- \$50 per person, per contract year;
- \$150 per family per contract year
- Waived for Diagnostic & Preventive Services

Lifetime Orthodontic Maximum

\$2,000

Class I

Basic Restorative 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
D0270	Bitewing – single radiographic image
D0272	Bitewing – two radiographic images
D0273	Bitewing – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewing – seven to eight radiographic images
D0330	Panoramic radiographic image
D0425	Caries susceptibility test

Preventive Services

D1110	Prophylaxis – adult
D1120	Prophylaxis – children
D1206	Topical fluoride varnish
D1208	Topical application of fluoride – excluding varnish
D1351	Sealant – per tooth
D1510	Space maintainer – fixed, unilateral
D1516	Space maintainer – fixed – bilateral, maxillary
D1517	Space maintainer – fixed – bilateral, mandibular
D1520	Space maintainer – removable, unilateral

Office of the Comptroller of the Currency

Dental Insurance Program

D1526	space maintainer—removable—bilateral, maxillary
D1527	space maintainer—removable—bilateral, mandibular
D1550	Re-cement or re-bond space maintainer
D1575	Distal shoe space maintainer—fixed—unilateral

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
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core
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

Endodontics

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
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

Office of the Comptroller of the Currency

Dental Insurance Program

- D3357** Pulpal regeneration – completion of treatment
- D3410** Apicoectomy – anterior
- D3421** Apicoectomy surgery – premolar (first root)
- D3425** Apicoectomy – molar (first root)
- D3426** Apicoectomy – (each additional root)
- D3430** Retrograde filling – per root
- D3450** Root amputation – per root

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
- 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 (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 procedures (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
- D4346** Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
- D4355** Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit.
- D4381** Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
- D4910** Periodontal maintenance
- D7921** Collection and application of autologous blood concentrate product

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

Office of the Comptroller of the Currency

Dental Insurance Program

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/ clasp 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)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)

Prosthodontic Services - Fixed

D6980	Fixed partial denture repair, by report
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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 elevation of mucoperiosteal flap and removal of bone and/or section of tooth
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 of residual tooth roots (cutting procedure)
D7251	Coronoectomy - intentional partial tooth removal
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7280	Exposure of an unerupted tooth

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 no in junction with extraction- 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
D7971	Excision of pericoronal gingiva
D7999	Unspecified oral surgery procedure, by report

Adjunctive Services

D9222	Deep sedation/general anesthesia - first 15 minute
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 - <u>each subsequent 15 minute increment</u>

Class III

Diagnostic Services

D0160	Detailed and extensive oral evaluation - problem-focused, by report
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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
D2740	Crown - porcelain/ceramic

Office of the Comptroller of the Currency

Dental Insurance Program

D2750	Crown - porcelain fused to high-noble metal	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D2751	Crown - porcelain fused to predominantly base metal	D6061	Abutment supported porcelain fused to metal crown (noble metal)
D2752	Crown - porcelain fused to noble metal	D6062	Abutment supported cast metal crown (high noble metal)
D2780	Crown - 3/4 cast high-noble metal	D6063	Abutment supported cast metal crown (predominantly base metal)
D2781	Crown - 3/4 cast predominantly base metal	D6064	Abutment supported cast metal crown (noble metal)
D2782	Crown - 3/4 cast noble metal	D6065	Implant supported porcelain/ceramic crown
D2783	Crown - 3/4 porcelain/ceramic	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D2790	Crown - full cast high-noble metal	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D2791	Crown - full cast predominantly base metal	D6068	Abutment supported retainer for porcelain/ceramic FPD
D2792	Crown - full cast noble metal	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D2794	Crown - titanium	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D2950	Core buildup, including any pins when required	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D2954	Prefabricated post and core in addition to crown	D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D2980	Crown repair necessitated by restorative material failure	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D2981	Inlay repair necessitated by restorative material failure	D6074	Abutment supported retainer for cast metal FPD (noble metal)
D2982	Onlay repair necessitated by restorative material failure	D6075	Implant supported retainer for ceramic FPD
D2983	Veneer repair necessitated by restorative material failure	D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D2990	Resin infiltration of incipient smooth surface lesions	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
Implants		D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
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)		

Office of the Comptroller of the Currency

Dental Insurance Program

D6090	Repair implant supported prosthesis, by report	D5214	Mandibular partial denture - cast metal framework with resin denture bases (including conventional clasps, rests and teeth)
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	D5282	Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary
D6094	Abutment supported crown (titanium)	D5283	Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular
D6095	Repair implant abutment, by report	D5710	Rebase complete maxillary denture
D6096	Remove broken implant retaining screw	D5711	Rebase complete mandibular denture
D6100	Implant removal, by report	D5720	Rebase maxillary partial denture
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	D5721	Rebase mandibular partial denture
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	D5730	Reline complete maxillary denture (chairside)
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	D5731	Reline complete mandibular denture (chairside)
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	D5740	Reline maxillary partial denture (chairside)
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	D5741	Reline mandibular partial denture (chairside)
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	D5750	Reline complete maxillary denture (laboratory)
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	D5751	Reline complete mandibular denture (laboratory)
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	D5760	Reline maxillary partial denture (laboratory)
		D5761	Reline mandibular partial denture (laboratory)

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 conventional clasps, rests and teeth)

Prosthodontic Services - Fixed

D6194	Abutment supported retainer crown for FPD (titanium)
D6210	Pontic - cast high noble metal
D6211	Pontic - cast predominantly base metal
D6212	Pontic - cast noble metal
D6214	Pontic - titanium
D6240	Pontic - porcelain fused to high noble metal
D6241	Pontic - porcelain fused to predominantly based metal
D6242	Pontic - porcelain fused to noble metal
D6245	Pontic - porcelain/ceramic

Office of the Comptroller of the Currency

Dental Insurance Program

D6545	Retainer – cast metal for resin bonded fixed prosthesis
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549	Resin retainer – 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
D6752	Retainer crown – porcelain fused to noble metal
D6780	Retainer crown – 3/4 cast high noble metal
D6781	Retainer crown – 3/4 cast predominantly base metal
D6782	Retainer crown – 3/4 cast noble metal
D6783	Retainer crown – 3/4 porcelain/ceramic
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
D6930	Re-cement or re-bond fixed partial denture

Adjunctive 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
D9944	occlusal guard – hard appliance, full arch
D9945	occlusal guard – soft appliance, full arch
D9946	occlusal guard – hard appliance, partial arch
D9941	Fabrication of athletic mouth guard
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	Limited 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

Office of the Comptroller of the Currency

Dental Insurance Program

- 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

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- 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

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 calendar year 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 calendar year.
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

Office of the Comptroller of the Currency

Dental Insurance Program

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 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 for OCC 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.
8. Sealants for teeth other than permanent molars are not covered.
9. Sealants provided on the same date of service and on the same tooth as a restorations of the occlusal surface are considered integral procedures.
10. Distal shoe space maintainer is a benefit to guide the eruption of the first permanent molar and is only covered for dependent children under the age of 19.

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.
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. Up to four different quadrants of root planing are payable in a 24-month period and no more than two quadrants of scaling and root planing are allowed on the same date of service.

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.

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 D4910 or D4346 procedures and up to two routine prophylaxes may be paid within a 12-consecutive-month period to the day, but the total may not exceed four procedures in a 12-consecutive-month period to the day.
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

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.
9. The fee for an alveoplasty performed by the same dentist/dental office in the same surgical area on the same date of service as extractions (D7140, D7210-D7250) is disallowed.

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 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 dentist, per year.

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.

Office of the Comptroller of the Currency

Dental Insurance Program

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) and repair of an implant abutment (D6095) are only payable by report upon Delta Dental dentist advisor review. 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. Cast unilateral removable partial dentures are not covered benefits.
12. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered benefits.
13. 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.

Office of the Comptroller of the Currency

Dental Insurance Program

14. Implants and related prosthetics may be covered and may be reimbursed as an alternative benefit as a three-unit fixed partial denture.
15. 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.
16. Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.
17. 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.
18. 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

Office of the Comptroller of the Currency

Dental Insurance Program

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 for which the patient would have no obligation to pay in the absence of this or any similar coverage.
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. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. Those performed by a dentist who is compensated by a facility for similar covered services performed for patients.
18. Those resulting from the patient's failure to comply with professionally prescribed treatment.
19. Telephone consultations.
20. Any charges for failure to keep a scheduled appointment.
21. Duplicate and temporary devices, appliances, and services.
22. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).

Office of the Comptroller of the Currency

Dental Insurance Program

23. Plaque control programs, oral hygiene instruction, and dietary instructions.
24. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered benefits.
25. 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.
26. Gold foil restorations.
27. 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.
28. 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.
29. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
30. 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.
31. Office infection control charges.
32. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
33. Adjunctive dental services as defined by applicable federal regulations.
34. 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.
35. Duplication of radiographic images for administrative purposes is not payable.
36. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.
37. Nitrous oxide.
38. Oral sedation.
39. State or territorial taxes on dental services performed.

Glossary

Adjudication

The processing of a claim through a series of edits to determine proper payment; “auto-adjudication” is the processing of a claim without any human intervention (also known as “drop-to-pay”).

Adjunctive Dental Care

Dental treatment that is medically necessary in the treatment of a non-dental condition.

Allowed Amount/Allowable Charge

The dollar amount used to calculate payment by Delta Dental based on the coverage percentage for the service(s) submitted on the claim.

Alternate Identification Number

An assigned identification number created to replace the use of the social security number for the identification of dental program enrollees. For the TRDP, the Department of Defense-issued DoD Benefits Number (DBN) may be used.

Annual Dental Accident Maximum Benefit

The separate annual maximum for procedures provided as a result of a dental accident. Not available under all programs; refer to each program’s Summary of Benefits chart for more information.

Annual Maximum Benefit

The total dollar amount that will be paid per enrollee during each benefit year, excluding orthodontic coverage and/or dental accident services, when applicable to the specific program. Also see Maximum Benefit Amount.

Annuitants

Federal employees who retired on an immediate annuity and survivors of those who retired on an immediate annuity or who died in service, as well as those receiving compensation from the Department of Labor’s Office of Workers’ Compensation Programs (called “compensationers”). Federal annuitants are sometimes referred to as “retirees.”

Approved Amount

The dollar amount used to calculate the total cost share due for the service(s) submitted on the claim. This is the maximum amount that can be charged to the patient and is also referred to as the Maximum Plan Amount (MPA). Network dentists have agreed to accept the approved amount (MPA) based on the agreements they have signed with Delta Dental. For non-Delta Dental dentists, this amount will be the same as the submitted amount.

Assignment of Benefits

This term refers to the subscriber’s/patient’s signature in the appropriate section on the claim form, authorizing Delta Dental to send payment for any covered service(s) directly to a non-Delta Dental dentist.

Balance Billing

Balance billing occurs when a Delta Dental network dentist bills an enrollee for amounts disallowed by Delta Dental. Network dentists have agreed to accept the fee approved as payment in full and are not allowed to bill an enrollee for any difference or balance between the Delta Dental approved amount and the submitted fee.

BENEFEDS

The agency that is responsible for the enrollment and premium administration system for programs under the Federal Employees Dental and Vision Insurance Program (FEDVIP).

Benefit

Dental services/procedures received by enrollees for which all or part of the cost is paid by their program.

Benefit Differential

This term is used to describe how payment is made for a covered service, based on whether the dentist providing the service is a network dentist or an out-of-network dentist for the particular program. For example, payment may be made at 80% for a covered service provided by a network dentist but may only be made at 60% percent when provided by an out-of-network dentist.

Benefit Year

The specific 12-month period in which an enrollee’s annual deductibles and maximums are applied when determining payment for covered services provided.

Birthday Rule

The rule defined by the National Association of Insurance Commissioners (NAIC) that states that when a child is covered under both parents’ dental plans, the plan of the parent whose birthday (month and day only) falls earlier in the calendar year is billed first. In cases where the child’s parents are divorced or separated, other factors must be considered.

By Report (R)

A narrative description used to report a service that requires additional information, usually in the form of a written explanation from the dentist, in order to be processed and/or considered for payment. A dental professional evaluates these narratives.

Claim

A written and documented request for payment submitted to a dental benefits plan. The request for payment should include the services and dates rendered, the cost by service, and a statement signed by both the enrollee and treating dentist attesting that services have been rendered. The completed request is considered a legal document and serves as the basis for payment of benefits.

Code on Dental Procedures and Nomenclature

A coding structure developed by the American Dental Association (ADA) to achieve uniformity, consistency and specificity throughout the dental industry in accurately reporting dental treatment. The Code has been designated as the national standard for reporting dental services by the federal government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is currently recognized by dental insurance companies nationwide. Coding and nomenclature in this handbook follow the Current Dental Terminology (CDT) and are the copyright of the ADA.

Coordination of Benefits (COB)

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

Coinsurance/Copayment/Cost Share

The percentage of the allowed amount not paid by Delta Dental for a covered procedure. Payment for this portion, known also as the “coinsurance,” “copayment” or “cost share,” is the patient’s responsibility.

Covered Procedure/Covered Service

A dental procedure or service provided and/or received in accordance with the policies of the program, to include any limitations and exclusions.

Date of Service (DOS)

The date a dental service was completed. This date should be indicated on the claim form when it is submitted for payment.

Deductible

The dollar amount that must be paid by the patient toward covered services before the program payment is applied to those services. Some covered services may be exempt from the deductible. The deductible, copayment and amounts over the annual maximum are often referred to as the enrollee’s “out-of-pocket” costs.

Enrollee

An individual (subscriber or dependent) covered by a benefit plan.

Exclusions

Dental services and/or procedures not covered under a benefit plan.

Explanation of Benefits (EOB)

A notification sent by the benefit plan to both the enrollee and dentist whenever a claim has been processed. The EOB provides information about the fees submitted, approved and allowed; applicable processing policies; and the patient’s copayment amount.

Fee Schedule

A list of the charges agreed to by a dentist and the dental insurance company for specific dental services by network agreement.

Generally Accepted Dental Protocols/Dental Necessity

A dental service or treatment that is necessary to treat decay, disease or injury of the teeth, or is essential for the care of the teeth and their supporting tissues and which is performed in accordance with generally accepted dental standards, as determined by multiple sources including but not limited to: relevant clinical research conducted by dental schools; current, recognized dental school standard-of-care curriculums; and organized dental groups such as the American Dental Association.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal initiative enacted in several stages over a period of years to ensure that people can keep their health insurance when changing jobs. This act also requires that electronic health care transactions adhere to specific coding and transmission standards and that privacy and security measures be implemented to protect health care information and prevent fraud. More information about HIPAA can be found at <http://aspe.os.dhhs.gov/asmnsimp>.

Limitations

Restrictive conditions stated in a dental benefit plan's contract, such as age, length of time covered and waiting periods, which affect an individual's or group's coverage. The contract may also exclude certain benefits or services, or it may limit the extent or conditions under which certain services are provided.

Maximum Allowable Benefit

The total dollar amount per enrollee that is paid during a specific period of time for covered services as specified in the benefit plan's contract provisions.

National Association of Insurance Commissioners (NAIC)

An association that assists state insurance regulators, individually and collectively, in serving the public interest and achieving fundamental insurance regulatory goals.

National Provider Identifier (NPI)

HIPAA mandated standard for a provider identifier for electronic claims processing. All providers are required to have an NPI-1.

Overbilling/Waiver of Copayment

According to the American Dental Association Principles of Ethics and Code of Professional Conduct, a dentist who offers to waive collection of a patient's copayment as required by the patient's dental plan and to accept the plan's "covered" percentage as payment in full is engaged in the practice of overbilling. This practice is considered by the ADA to be deceptive, misleading and thereby unethical because it appears that the dentist's charge to the patient for the services rendered is higher than it actually is. Overbilling can lead to higher costs for dental care and limit access to affordable dental coverage under all dental plans.

Participating Network Dentist / In-network Dentist

A licensed dentist who "participates" in the specific dental program by agreeing to accept the program allowable fees for providing covered treatment, complete and submit claims paperwork on behalf of the program's, and receive payment directly from Delta Dental.

Pre-treatment Estimate

A non-binding, written estimate of how much a specific dental plan covers for a particular service. Dentists are encouraged to submit pre-treatment estimate requests for the more complex and/or expensive treatment.

Reimbursement

Payment made by a third party to a beneficiary (enrollee) or to a dentist on behalf of the beneficiary (enrollee), toward expenses incurred for services covered by the dental plan's contractual arrangement.

Waiting Period

The period of time of continuous enrollment (generally, 12 months) that an enrollee in a dental plan must complete before specific categories of dental procedures become payable benefits.