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:

- TRICARE Retiree Dental Program (TRDP)
- Federal Employees Dental Program (FEDP)
- Veterans Affairs Dental Insurance Program (VADIP)
- Public Health Service Active Duty Dental Program (PHS ADDP)

The FGP division has been entrusted as the steward for dental programs offered at the national level through various federal government agencies. Each of these programs is offered under the authority of federal law.

In processing claims, we use the Delta Dental National Processing Guidelines established by the Delta Dental Plans Association (DDPA). In some situations, we are obligated by our contracts to process claims differently from local Delta Dental or DDPA guidelines in order to be in accordance with federal laws that may have preemption over certain state and/or local laws.

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.

We think you will find the information in both 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
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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 predeterminations.**
  With DOT, you can submit your own claims and predeterminations 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 predeterminations 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.

We will send you an email after you have registered for DOT, provide we have an email address on file for your service office. The email will include 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 Dental Office Toolkit (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.
Contact Information

> 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).

> Dental Office Toolkit (DOT)

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

> 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.

> Toll-free number for dental offices: **844-825-8111**

Dental offices can verify patient enrollment and benefits for members of all Federal Government Program groups.
TRICARE Retiree Dental Program
trdp.org
Claim Submission/Written Inquiries:
Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

Federal Employees Dental Program
deltadentalfeds.org
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
deltadentalvadip.org
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
About Delta Dental’s Networks

**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 Legion**

Delta Dental’s Legion network dentists are “contracted” dentists who are exclusive to programs offered under Department of Defense contracts, such as the TRICARE Retiree Dental Program. Delta Dental Legion network dentists agree to provide services at contracted fees that meet the program’s cost-management criteria. The Delta Dental Legion network was formerly known as the Delta Dental Select USA network.

**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.

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

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

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.

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 programs that are offered through the Department of Defense and administered by Delta Dental of California. Currently, the TRICARE Retiree Dental Program (TRDP) is the only program that considers Delta Dental Legion network dentists to be participating dentists. By joining the Delta Dental Legion network, you will be demonstrating your support of the millions of military retirees who have devoted their lives to serving our country.

It’s easy to join the Delta Dental Legion dentist network. Simply go to the TRDP website at trdp.org and find the “For Dentists” section. Click on “Join the Network” and print copies of the Delta Dental Legion Network Participation Application and Attestation form, Participating Dentist Agreement and application checklist. Complete all areas of the application/attestation, sign the form and date it. After reviewing the agreement, please sign and date it also. Return the completed and signed application/attestation and agreement forms, along with the required credentialing documents as noted in the checklist, to the Federal Government Programs division in one of three ways:

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

Delta Dental is required to confirm the professional qualifications of dentists and specialists who treat patients enrolled in the TRDP. We verify each treating dentist’s credentials as part of the initial application to join Delta Dental networks and again no less than every three years thereafter.

Delta Dental’s credentialing process is based on the standards of federal and state accreditation and regulatory agencies. The process involves verifying the validity of each treating dentist’s submitted information with regulatory agencies, professional associations and educational institutions to ensure that the dentist is legally qualified to practice. 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. The credentialing procedures focus on confirming the following elements:

• Completed Application/Attestation Form that attests to ability to practice
• Valid and current license to practice (state dental license)
• Hospital privileges, if applicable
• Valid, current registrations and permits, including those for DEA, conscious sedation, oral conscious sedation and general anesthesia, where applicable
• Board Certification of specialty/residency completion, if applicable
• Current acceptable professional liability insurance coverage limits. The minimum amounts required are $100,000/$300,000 or the amount that meets the requirement of the state where the dentist holds his/her license and provides services, whichever is greater.
• History of professional liability claims, including previous lawsuits, if any
• Review of application processing to ensure professional questions are answered and attestation has been signed
• National Practitioner Data Base (NPDB) information (SSN is required for query purposes)
• Federal sanctions (including Medicare and Medicaid) determined by the U.S. Department of Health and Human Services Office of the Inspector General
• Sanctions against licensure/state license limitations
• Prior work history

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

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.

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.

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. If the claim form does not contain this field, please list each item on a separate line.
- 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).

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**

**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.

**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.

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.

**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
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.

The following are the processing policy codes that will be used to indicate when the Type 1 NPI is missing from the electronic claim or does not match the NPF records:

- AP21013
- MI22011
- MI22012
- MI22013
- MI22016

Please refer to the Processing Policy Codes section of this Handbook for a detailed description of these codes.

**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 now 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 Explanation of Benefits (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. An exception to this rule applies to those who have coverage under the TRICARE Retiree Dental Program (TRDP). As a voluntary plan (not a retirement plan), the TRDP follows the “effective-first date” rule. When a patient has coverage through the TRDP and another dental plan, the plan in which the patient has been enrolled the longest is considered primary.
• 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. 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 or 18 months, whichever is less. 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 (or less if the active treatment is less than 18 months) as measured from the banding/appliance date 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.

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.
Below are policy codes most commonly used in processing claims for federal government dental programs. Each code is listed by its number along with the explanation that appears on the Explanation of Benefits (EOB). Additional information has been provided where necessary for further clarification.

**Administrative Policy (AP) Codes**

Administrative Policy codes are used for informational purposes and generally do not require any further action by the dental office.

**AP00017** Based on a review of the information submitted, Delta Dental has changed one or more of the following: the tooth number/area of oral cavity, procedure code, tooth surface, date of service and/or submitted fee.

**AP00059** The optional allowance provision of this contract provides an amalgam restoration towards a composite resin restoration on posterior teeth.

**AP00067** The patient has reached the maximum amount allowed for the benefit year.

**AP00420** Based on the date of service, the patient’s enrollment address is in an area without adequate numbers of network dentists. Delta Dental has calculated reimbursement for these services to ensure the patient’s expenses do not exceed those that would otherwise be incurred if access to sufficient network dentists had been available.

**AP00856** Delta Dental is unable to process this claim. Please note: Primary enrollee must contact Customer Service for assistance.

**AP00921** The procedure was received with no fee; if this is an error, please resubmit.

**AP21013** Dentist: the EOB is based on a paper claim submission of a prior submitted electronic claim. On the electronic submission the NPI type 1 (rendering dentist) did not match the file information listed on the National Provider File (NPF). Based on the license number submitted on the paper claim for the rendering dentist, the NPI-1 from the NPF is noted at the top of the EOB following the license number. The NPI-1 is always required on claims submitted electronically. Please verify with your local Delta Dental the rendering dentist’s NPI-1 is correctly listed on the NPF and/or verify with your practice management software vendor that when submitting electronic claims, the NPI-1 is not dropped or changed to your NPI-2 (business). Until corrected, this will cause claim denials of your electronically submitted claims.

**Exclusions and Limitations (EL) Codes**

Exclusions and Limitations codes provide an explanation as to why a service was denied or disallowed.

**EL00061** This procedure is not a covered benefit of this dental program and therefore not payable by the Plan.

**EL00072** The maximum allowable has been paid for this service.

**EL00151** Comprehensive and periodic evaluations are limited to twice in a 12-month period.

**EL00154** A panoramic radiograph or intraoral complete (full mouth) series is a covered benefit once in a 60-month period.

**EL00155** Our records show Delta Dental paid the maximum limit of four diagnostic periapical x-rays (non-emergency service-related) within a 12-month period. Payment for additional periapical film(s) is the patient’s responsibility.

**EL00156** Payment for bitewing radiographs, whether limited to a single, two, three or four films are benefits once in a 12-month period. This includes those take as part of a complete full mouth series.

**EL00163** Cleanings and/or fluoride treatments are limited to twice in a 12-month period.

**EL00569** Specialized techniques are not covered benefits.
EL00965 This procedure is a covered benefit with a contractual waiting period. The waiting period has not been met as of the date of service, therefore the payment for the service(s) is the patient's responsibility.

EL00966 The patient's dental coverage was not in effect for this date of service. Payment for the service(s) is the patient's responsibility.

Missing Information (MI) Codes

Missing Information codes indicate services we are unable to process, resulting in a “denial” of the service(s). In order for Delta Dental to process the service(s), include the missing information on the Explanation of Benefits (EOB) statement or attach it to the EOB as necessary, and return the EOB to the address shown on the statement.

MI00070 Please note that this procedure code is an unspecified ADA code. Please indicate a valid ADA code with a clear description of the service provided on this Explanation of Benefits (EOB) and return to Delta Dental at the address shown. NOTE: If this code was used for OSHA/infection control, Delta Dental network dentists cannot charge for this service. If this code is for applicable state tax, the patient is responsible for this charge.

MI01001 Please indicate amount paid by the primary carrier on the Explanation of Benefits and return to Delta Dental at the address shown.

MI07006 Please note that this procedure code is not a valid ADA code. Please indicate a valid ADA code with a clear description of the service provided on this Explanation of Benefits (EOB) and return to Delta Dental at the address shown. NOTE: If this code was used for OSHA/infection control, Delta Dental network dentists cannot charge for this service. If this code is for applicable state tax, the patient is responsible for this charge.

MI07010 Please provide clinical documentation that supports the dental necessity of the specific treatment indicated on the Explanation of Benefits (EOB); please attach the documentation to the EOB and return to Delta Dental at the address shown. All “by report” procedure codes require supporting clinical documentation; only periodontal procedures require current periodontal charting.

MI22011 Please note we are unable to process this claim. The treatment office address and the rendering dentist NPI type 1 submitted on the claim does not match Delta Dental’s National Provider File (NPF) records. We recommend that the dentist contact the local Delta Dental member company to update his/her records. Claims are processed according to the information on the National Provider File records, please submit accordingly.

MI22012 Please note we are unable to process this claim. The treatment office address submitted on the claims, does not match the business/tax identification number and the rendering treatment dentist NPI type 1 on file with the Delta Dental’s National Provider File records. We recommend that the dentist contact the local Delta Dental member company to update his/her records. Claims processed according to the information on the National Provider File records, please submit accordingly.

MI22013 Please note we are unable to process this claim. The rendering dentist NPI type 1 submitted on the claim does not match the treatment office on file with the Delta Dental’s National Provider File records. We recommend that the dentist contact the local Delta Dental member company to update his/her records. Claims processed according to the information on the National Provider File records, please submit accordingly.

MI22016 Please note we are unable to process this claim. The rendering dentist NPI type 1 submitted on the claim does not match Delta Dental's National Provider File (NPF) records. We recommend that the dentist contact the local Delta Dental member company to update his/her records. Claims are processed according to the information on the National Provider File records, please submit accordingly.

MI07011 Please attach copies of the preoperative radiographs (radiographic copies must be of diagnostic quality, current and dated, and properly labeled) to this Explanation of Benefits (EOB) and return to Delta Dental at the address shown.
**Program Policy (PP) Codes**

Program Policy codes indicate services for which an adjustment was made per a program-specific policy.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP00102</td>
<td>A panoramic radiograph with bitewings or additional film(s) taken as a series, is the same as a full mouth series and paid as such.</td>
</tr>
<tr>
<td>PP00207</td>
<td>Payment is made for a surface once within a 24-month period, regardless of the number or combination of restorations place on that surface. These procedure code(s) and/or surfaces were previously paid.</td>
</tr>
<tr>
<td>PP00906</td>
<td>Procedure is considered to be in conjunction with other services provided.</td>
</tr>
<tr>
<td>PP00968</td>
<td>This procedure was denied due to a duplicate service being submitted on this or a prior claim.</td>
</tr>
</tbody>
</table>

**Program Specific Policy Codes — Federal Employees Dental Program (FEDP):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP00971</td>
<td>This pre-treatment estimate summarizes the benefits available under the patient’s primary coverage. You will receive a separate estimate summarizing the benefits available under the patient’s secondary coverage. When treatment is completed, please submit this estimate for payment. You should not submit the secondary pre-treatment estimate until after you have received the primary payment.</td>
</tr>
<tr>
<td>MI01001</td>
<td>Please indicate amount paid by primary carrier on this Explanation of Benefits and return to Delta Dental at the address shown.</td>
</tr>
</tbody>
</table>

**Veterans Affairs Dental Insurance Program (VADIP):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EL00965</td>
<td>This procedure is a covered benefit with a contractual waiting period. The waiting period has not been met as of the date of service; therefore, the payment for the service(s) is the patient’s responsibility.</td>
</tr>
</tbody>
</table>
The TRICARE Retiree Dental Program (TRDP) is a voluntary dental benefits program offered to retirees of the Uniformed Services and their family members. The Uniformed Services include the Army, Navy, Air Force, Marine Corps, Coast Guard, U.S. Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA).

The TRDP was authorized by Congress in 1997 and is administered by Delta Dental of California under contract with the U.S. Department of Defense. Delta Dental has administered the TRDP since February 1, 1998 and after having been awarded the most recent contract that began January 1, 2014, will continue its administration of the program through December 2018.

The TRDP consists of two plans—the Basic TRDP and the Enhanced TRDP. Enrollment in the basic program is no longer offered; however, those already in the Basic TRDP may remain enrolled or can upgrade to the Enhanced TRDP.

The retired sponsor pays 100% of the premium for TRDP coverage—either single-person, two-person or family coverage. There is no government funding for the TRDP. Automatic deductions from the sponsor’s retirement pay are required for payment of monthly TRDP premiums.

If retirement pay is unavailable or insufficient to allow the government-mandated automatic deduction, the retired sponsor must pay the monthly premium through electronic funds transfer (EFT) or recurring credit card transactions.

The service area is worldwide for those enrolled in the Enhanced TRDP; however, access to the participating TRDP dentist network is limited to the 50 United States, District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. The Delta Dental PPO (DPO in Texas) and the Delta Dental Legion dentist networks comprise what is considered the “participating” network for the TRDP.

Although Delta Dental Premier network dentists are considered out-of-network dentists for the TRDP, Delta Dental will still make payment directly to a Premier dentist, with the dentist held to the Premier network’s maximum plan allowance (MPA) for full payment by the patient of his/her cost-share plus the difference in the MPA “approved” amount. Non-Delta Dental dentists are also considered “out-of-network” for the TRDP; the patient is responsible for his/her own cost share and the difference up to the submitted fee. For treatment provided by an out-of-network dentist, Delta Dental will generally make payment to the patient unless there is an Assignment of Benefits on the claim.

NEW Benefits for 2017

D1575 Distal shoe space maintainer—fixed—unilateral
D4346 Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure*
D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure*
D6104 Bone graft at time of placement*

*Applicable to Enhanced Program only
## Summary of Benefits

<table>
<thead>
<tr>
<th>TRICARE Retiree Dental Program Benefits - Effective 01/01/14</th>
<th>Basic Program</th>
<th>Enhanced Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits by Category</strong></td>
<td><strong>Year One +</strong></td>
<td><strong>Year One</strong></td>
</tr>
<tr>
<td>Diagnostic</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive</td>
<td>80-100%</td>
<td>80-100%</td>
</tr>
<tr>
<td>Basic Restorative(^1)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>60%</td>
<td>60-100%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Major Restorative(^1)</td>
<td>NAB(^*)</td>
<td>NAB(^*)</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>NAB(^*)</td>
<td>NAB(^*)</td>
</tr>
<tr>
<td>Dental Implants</td>
<td>NAB(^*)</td>
<td>NAB(^*)</td>
</tr>
<tr>
<td>Orthodontics(^2)</td>
<td>NAB(^*)</td>
<td>NAB(^*)</td>
</tr>
<tr>
<td>Dental Accident</td>
<td>NAB(^*)</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Deductible**

- **Annual Deductible per patient\(^3, 4\)**: $50-$150
- **Maximums**
  - **Annual Maximum per patient\(^5\)**: $1000, $1300
  - **Annual Maximum for Dental Accident**: NAB\(^*\), $1200
  - **Lifetime Maximum for Orthodontics**: NAB\(^*\), $1750

\(^*\)NAB = Not a Benefit

\(^1\)One-, two- and three-surface posterior composites are paid under the Enhanced Program. An amalgam allowance is given for a four-surface posterior composite under the Enhanced Program. Posterior composites are not covered under the Basic Program with no allowance given for amalgam when performed.

\(^2\)Orthodontic coverage is for both children and adults

\(^3\)Diagnostic and preventive services are covered at 100% — deductible is not applied to these services.

\(^4\)Individual member deductible is $50 with maximum Family deductible @ $150

\(^5\)Diagnostic and preventive services are covered at 100% — annual maximum is not applied to these services
Enhanced Program — Policies, Covered Benefits, Limitations and Exclusions

General Policies

1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (non-covered services) for billing purposes with the exception of dental services provided overseas.

2. Claims received on or after the first of the month following 12 months of the date of service are not payable by Delta Dental. The fees for Delta Dental's portion of the payment are not chargeable to the patient by a participating network dentist.

3. Participating network dentists must agree not to charge the patient more than the deductible and/or cost share amount as shown on the Explanation of Benefits.

4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.

5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.

6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).

7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.

8. Postoperative care and evaluation are included in the fee for the service.

9. The fee for medicaments/solutions is part of the fee for the total procedure.

10. Procedure codes may be modified by Delta Dental based on the description of service and supporting documentation.

11. For procedures limited to a specific frequency during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.

12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.

13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient’s responsibility.

14. Covered procedures, except orthodontic procedures as described in this benefits booklet, are payable only upon completion of the procedure billed.

15. Services must be necessary 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 network 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.

16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.

17. Effective July 1, 2007, the TRICARE medical plan implemented coverage for medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for pediatric patients age 5 and under (this general anesthesia benefit is not covered by the TRDP). Since preauthorization for this benefit is required, patients should contact their regional contractors for specific instructions. Information is also available at tricare.mil.

18. An “R” to the right of the procedure code means “by report” and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits.

19. An “X” to the right of the procedure code means that these services will be paid only when a current radiographic image is submitted with the dental claim.
**Diagnostic Services**

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with a primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0160 R</td>
<td>Detailed and extensive oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0170 R</td>
<td>Re-evaluation—limited, problem-focused (established patient; not post-operative visit)</td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation—post-operative visit</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0340</td>
<td>2D cephalometric radiographic image—acquisition, measurement and analysis</td>
</tr>
<tr>
<td>D0425 R</td>
<td>Caries susceptibility tests</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
</tr>
</tbody>
</table>

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.
2. Payment is limited to any two evaluations, comprehensive and/or periodic, in a 12-month period. Payment for more than two evaluations, comprehensive and/or periodic, in a 12-month period is the patient’s responsibility. This limitation includes procedure D0145, “oral evaluation for a patient under three years of age and counseling with primary caregiver.”
3. One comprehensive oral evaluation (D0150 - comprehensive oral evaluation, D0160 - detailed and extensive oral evaluation or D0180 - comprehensive periodontal evaluation) is payable once per dentist per year and only if related to covered dental procedures. Additional evaluations are considered periodic evaluations and are paid as such.
4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.
5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.
6. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.
7. 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.
8. 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.
9. 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.
10. 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.

11. Payment for panoramic radiographic images is limited to one within a 48-month period.

12. Payment for periapical radiographic images (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.

13. 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.

14. Radiographic images of non-diagnostic quality are not payable.

15. Duplication of radiographic images for administrative purposes is not payable.

16. Test reports must describe the pathological condition, type of study and rationale.

17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.

18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

19. Detailed and extensive oral evaluations (D0160) are limited to once per patient per dentist, per year. They will not be paid if related to non-covered medical or dental procedures.

20. Re-evaluations (D0170) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to non-covered medical or dental procedures.

21. Two cephalometric radiographic images (D0340) are payable for orthodontic diagnostic purposes only. The fee for additional radiographic images taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

22. 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.

Preventive Services—100% coverage

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult (two per 12-month period)</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—child (two per 12-month period)</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride - excluding varnish</td>
</tr>
</tbody>
</table>

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.

2. Two prophylaxes for non-diabetic adults and children are covered in a period of 12 consecutive months to the day. One periodontal procedure D4346 or D4910 can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may also substitute both prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and a second one covered at 60%. Payment is limited to two prophylaxes or one prophylaxis and one periodontal procedure or two periodontal procedures in 12 consecutive months to the day. Payment for additional cleanings is the non-diabetic patient’s responsibility.

3. Three prophylaxes for adults and children with Type 1 or Type 2 diabetes are covered in a period of 12 consecutive months to the day. One periodontal procedure D4346 or D4910 can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may substitute two prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and the second and third procedures covered at 60%. A statement from the patient’s physician documenting the patient’s medical condition must be provided.
4. Two fluoride treatments for both adults and children are covered in a period of 12 consecutive months. This limitation includes procedure D1206, “topical application of fluoride varnish.” Payment for additional fluoride treatments is the patient’s responsibility.

5. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.

6. 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.

7. 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.

8. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.

9. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

### Preventive Services—80% coverage

**Coverage:** 80%

**Patient Pays:** 20%

**Subject to Deductible:** yes

**Applies to Maximum:** yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in a moderate-to-high-caries-risk patient—permanent tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed - unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed - bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable - unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable - bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>

The following policies apply to preventive services covered at 80%:

10. Sealants are only covered on permanent molars through age 18.

11. One sealant per tooth is covered in a three-year period.

12. Sealants are only payable for molars that are caries free with no previous restorations on the mesial, distal or occlusal surfaces.

13. Sealants for teeth other than permanent molars are not covered.

14. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.

15. Sealants are covered for prevention of occlusal pit and fissure type cavities. Sealants provided for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.

16. The tooth number of the space to be maintained is required when requesting payment for space maintainers.

17. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.

18. 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).

19. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.

20. Repair of a damaged space maintainer is not covered.

21. Recementation of space maintainers is payable once within 12 months.

22. Space maintainers are not covered for patients 14 years and older.

23. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by Delta Dental or chargeable to the patient by a participating network dentist.

24. Distal shoe space maintainer (D1575) is a benefit to guide the eruption of the first permanent molar and is not covered for patients 14 years and older.
The following policies apply to restorative services covered at 80%:

1. Coverage is for basic restorative services of amalgam fillings, anterior composite restorations, and one-, two- and three-surface posterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.

2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.

3. Replacement of a restoration by the same dentist or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.

4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents, gingivectomy, infection control and expenses for compliance with OSHA regulations, etc. is not payable.

5. 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.

6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review.

7. Posterior restorations not involving the occlusal surface are paid as one-surface restorations, subject to review.

8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.

9. An allowance for comparable amalgam restorations with a patient cost share of 20% is allowed when the patient opts for non-covered resin procedure code D2394 (resin-based composite-four or more surfaces, posterior) on posterior teeth. The patient is responsible for the difference between the dentist’s charge for the posterior resin and the TRDP paid amount.

10. Radiographic images may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.
11. Pin retention is payable once per restoration to the same dentist or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.

12. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 36 months is not covered.

13. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.

14. Pin retention and buildups on primary teeth are covered in the fee for the restoration.

15. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.

16. Recementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.

17. After six months from the initial cementation date, recementation of crowns is payable once within 12 months.

18. Payment for a prefabricated resin crown (D2932) will be made when resin-based composite crowns are performed.

**Major Restorative Services**

Coverage: 50% after 12 months  
Patient Pays: 50% after 12 months  
Subject to Deductible: yes  
Applies to Maximum: yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2542 X</td>
<td>Onlay—metallic - two surfaces</td>
</tr>
<tr>
<td>D2543 X</td>
<td>Onlay—metallic - three surfaces</td>
</tr>
<tr>
<td>D2544 X</td>
<td>Onlay—metallic - four or more surfaces</td>
</tr>
<tr>
<td>D2740 X</td>
<td>Crown—porcelain/ceramic substrate</td>
</tr>
<tr>
<td>D2750 X</td>
<td>Crown—porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D2751 X</td>
<td>Crown—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D2752 X</td>
<td>Crown—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D2780 X</td>
<td>Crown—3/4 cast high noble metal</td>
</tr>
<tr>
<td>D2781 X</td>
<td>Crown—3/4 cast predominantly base metal</td>
</tr>
<tr>
<td>D2782 X</td>
<td>Crown—3/4 cast noble metal</td>
</tr>
<tr>
<td>D2783 X</td>
<td>Crown—3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D2790 X</td>
<td>Crown—full cast high noble metal</td>
</tr>
<tr>
<td>D2791 X</td>
<td>Crown—full cast predominantly base metal</td>
</tr>
<tr>
<td>D2792 X</td>
<td>Crown—full cast noble metal</td>
</tr>
<tr>
<td>D2794 X</td>
<td>Crown—titanium</td>
</tr>
<tr>
<td>D2950 X</td>
<td>Core buildup, including any pins when required</td>
</tr>
<tr>
<td>D2952 X</td>
<td>Post and core in addition to crown, indirectly fabricated</td>
</tr>
<tr>
<td>D2954 X</td>
<td>Prefabricated post and core in addition to crown</td>
</tr>
<tr>
<td>D2980 R</td>
<td>Crown repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
</tr>
</tbody>
</table>

The following policies apply to major restorative services covered at 50% after 12 months:

20. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

21. Facings on crowns posterior to the first molar position are considered to be cosmetic components. An allowance is made for a full cast crown.

22. After six months from the initial cementation date, recementation of cast crowns is payable once within 12 months.

23. Cast restorations are covered benefits only when necessary to replace natural 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.

24. The charge for a crown or onlay is considered to 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.

25. Onlays, permanent single crown restorations and necessary posts and cores for patients under 14 years of age are excluded from coverage unless specific rationale is provided indicating the reason for such treatment.

26. 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.

27. Temporary crowns placed in preparation for a permanent crown are considered integral to the placement of the permanent crown and are not payable as a separate procedure.

28. Recementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts within six months of placement by the same dentist is considered integral to the original procedure.

29. Onlays, crowns, and posts and cores are payable to restore a natural tooth due to decay or fracture. However, if the degree of breakdown does not qualify for a cast restoration, a benefit allowance will be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.

30. 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 and are considered integral to the buildup.

31. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.

32. Cast restorations and substructures include pins. A separate fee is not covered.

33. Veneers are not covered benefits. An allowance will be made for a resin restoration on an anterior tooth based on the degree of breakdown.

34. Porcelain/ceramic inlays and onlays are not covered benefits. An alternate benefit allowance toward a porcelain/ceramic inlay may be made with a corresponding amalgam restoration on a posterior tooth, and a resin restoration on an anterior tooth. An optional benefit allowance toward a porcelain/ceramic onlay may be made with a metallic onlay.

35. The completion date for crowns, onlays and buildups is the cementation date.

36. Resin or metallic inlays and resin onlays are not covered benefits. An alternate benefit allowance may be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.

37. Glass ionomer restorations are not covered benefits.

38. Gold foil restorations are not covered benefits.

39. Cast crowns with resin facings are not covered benefits

**Endodontic Services**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3120 R</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar (excluding final restoration)</td>
</tr>
<tr>
<td>D3332 R</td>
<td>Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy—anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy—bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy—molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification—interim medication replacement (apical closure/ calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification—final visit (includes completed root canal)</td>
</tr>
</tbody>
</table>
therapy—apical closure/calcific repair of perforations, root resorption, etc.)

D3410 Apicoectomy—anterior
D3421 Apicoectomy—bicuspid (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

The following policies apply to endodontic services:

1. 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.
2. An indirect pulp cap is only payable once per tooth by the same dentist.
3. A direct pulp cap is included in the fee for the restoration or palliative treatment.
4. 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.
5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.
6. Endodontic procedures in conjunction with overdentures are not covered benefits.
7. The completion date for endodontic therapy is the date the tooth is sealed.
8. 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.
9. 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.
10. 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.
11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.
12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.
13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed with codes D3310 – D3330, D3346 – D3348, or D3351– D3353 on the same day or within 30 days (same tooth/same dentist/same office).

Periodontic Services – 100% coverage

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

D4346 Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
D4910 Periodontal maintenance (one per 12-month period when substituted – see policies below)

The following policies apply to periodontic services covered at 100%:

1. For non-diabetic adults and children in active periodontal therapy, one periodontal procedure D4346 or D4910 may be substituted for one of the annual routine prophylaxes and be covered at 100% within a within a period of 12 consecutive months to the day. The patient may also substitute both prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and the second and third procedures covered at 60% (see Preventive Services above).
2. For adults and children with Type 1 or Type 2 diabetes who are in active periodontal therapy, one periodontal procedure D4346 or D4910 can be substituted for one of the three prophylaxes and be covered at 100% in a period of 12 consecutive months to the day. The patient may substitute two prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one periodontal procedure D4346 or D4910 covered at 100% and the second and third procedures covered at 60%. A statement from the patient’s physician documenting the patient’s medical condition...
Periodontic Services - 60% coverage

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210 R</td>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211 R</td>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4240 R</td>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241 R</td>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4245 R</td>
<td>Apically positioned flap</td>
</tr>
<tr>
<td>D4249 X</td>
<td>Clinical crown lengthening—hard tissue</td>
</tr>
<tr>
<td>D4260 R</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure)—four or more contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4261 R</td>
<td>Osseous surgery (including flap entry and closure)—one to three contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4263 R</td>
<td>Bone replacement graft—retained natural tooth—first site in quadrant</td>
</tr>
<tr>
<td>D4264 R</td>
<td>Bone replacement graft—retained natural tooth—each additional site in quadrant</td>
</tr>
<tr>
<td>D4266 R</td>
<td>Guided tissue regeneration—resorbable barrier, per site</td>
</tr>
<tr>
<td>D4267 R</td>
<td>Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)</td>
</tr>
<tr>
<td>D4270 R</td>
<td>Pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>D4273 R</td>
<td>Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position</td>
</tr>
<tr>
<td>D4277 R</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4278 R</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site</td>
</tr>
</tbody>
</table>

The following policies apply to periodontic services covered at 60%:

3. 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.

4. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.

5. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.

6. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.

7. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.

8. Bone grafts, soft tissue grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of natural teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, existing implants or other non-periodontal surgical procedures.
9. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

10. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.

11. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same dentist.

12. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery, periodontal maintenance, and scaling in the presence of generalized moderate or severe gingival inflammation.

13. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.

14. Up to two periodontal procedures D4346 or D4910 may be paid within a 12-consecutive-month period to the day for non-diabetic enrollees and up to three procedures D4346 or D4910 procedures may be paid within a 12-consecutive-month period to the day for diabetic enrollees (see policies 1 and 2 applicable to periodontic services covered at 100%, above).

15. Full-mouth debridement is a benefit once per patient per lifetime.

16. One crown lengthening per tooth, per lifetime, is covered.

17. 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.

18. Subepithelial connective tissue grafts are payable at the level of free soft tissue grafts.

19. An apically positioned flap is subject to documentation when performed and when not related to implants.

### Prosthodontic Services, Removable and Fixed

Coverage: 50% after 12 months  
Patient Pays: 50% after 12 months  
Subject to Deductible: yes  
Applies to Maximum: yes

#### Prosthodontics, Removable

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture—mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture—maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture—mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust complete denture—maxillary</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture—mandibular</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture—maxillary</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture—mandibular</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth—complete denture (each tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base—partial denture</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework—partial denture</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp—per tooth</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth—partial denture, per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture—per tooth</td>
</tr>
</tbody>
</table>
D670 Replace all teeth and acrylic on cast metal framework (maxillary)—partial denture
D671 Replace all teeth and acrylic on cast metal framework (mandibular)—partial denture
D710 Rebase complete maxillary denture
D711 Rebase complete mandibular denture
D720 Rebase maxillary partial denture
D721 Rebase mandibular partial denture
D730 Reline complete maxillary denture (chairside)
D731 Reline complete mandibular denture (chairside)
D740 Reline maxillary partial denture (chairside)
D741 Reline mandibular partial denture (chairside)
D750 Reline complete maxillary denture (laboratory)
D751 Reline complete mandibular denture (laboratory)
D760 Reline maxillary partial denture (laboratory)
D761 Reline mandibular partial denture (laboratory)
D810 Interim complete denture (maxillary)
D811 Interim complete denture (mandibular)
D820 Interim partial denture (maxillary)
D821 Interim partial denture (mandibular)
D850 Tissue conditioning, maxillary
D851 Tissue conditioning, mandibular

**Prosthodontics, Fixed**

D6210 X Pontic—cast high noble metal
D6211 X Pontic—cast predominantly base metal
D6212 X Pontic—cast noble metal
D6214 X Pontic—titanium
D6240 X Pontic—porcelain fused to high noble metal
D6241 X Pontic—porcelain fused to predominantly base metal
D6242 X Pontic—porcelain fused to noble metal
D6245 X Pontic—porcelain/ceramic
D6540 X Retainer—cast metal for resin bonded fixed prosthesis
D6545 X Retainer—porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer—or resin bonded fixed prosthesis
D6610 X Retainer onlay—cast high noble metal, two surfaces
D6611 X Retainer onlay—cast high noble metal, three or more surfaces
D6612 X Retainer onlay—cast predominantly base metal, two surfaces
D6613 X Retainer onlay—cast predominantly base metal, three or more surfaces
D6614 X Retainer onlay—cast noble metal, two surfaces
D6615 X Retainer onlay—cast noble metal, three or more surfaces
D6634 X Retainer onlay—titanium
D6740 X Retainer crown—porcelain/ceramic
D6750 X Retainer crown—porcelain fused to high noble metal
D6751 X Retainer crown—porcelain fused to predominantly base metal
D6752 X Retainer crown—porcelain fused to noble metal
D6780 X Retainer crown—3/4 cast high noble metal
D6781 X Retainer crown—3/4 cast predominantly base metal
D6782 X Retainer crown—3/4 cast noble metal
D6783 X Retainer crown—3/4 porcelain/ceramic
D6784 X Retainer crown—titanium
D6790 X Retainer crown—full cast high noble metal
D6791 X Retainer crown—full cast predominantly base metal
D6792 X Retainer crown—full cast noble metal
D6794 X Retainer crown—titanium
D6930 Re-cement or re-bond fixed partial denture
D6980 R Fixed partial denture repair necessitated by restorative material failure

The following policies apply to prosthodontic services, removable and fixed:

1. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures is included in the fee for these procedures.

2. Removable cast base partial dentures for patients under 16 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment.
3. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.

4. Tissue conditioning is limited to twice per denture within 36 months.

5. Payment for the replacement of missing natural teeth will be made up to the normal complement of natural teeth. Additional pontics are optional and, if placed should be done with the agreement of the patient to assume the additional cost. (Benefits for pontics are based on the number necessary for the spaces, not to exceed the number of missing teeth.)

6. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.

7. Cast restorations and substructures include pins.

8. After six months from the initial recementation date, recementation of fixed partial dentures, inlays or onlays is payable once within 12 months.

9. The permanent cementation date is considered to be the completion date for crowns and fixed bridges.

10. Adjustments provided within six months of the insertion of an initial or replacement denture are integral to the denture.

11. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.

12. A reline/rebase is covered once in any 36 months.

13. The fee for the complete replacement of denture base material (rebase) includes a reline.

14. Reline or rebase of an existing appliance will not be covered when such procedures are performed in addition to a new denture for the same arch.

15. Fixed partial dentures, buildups, and posts and cores for patients under 16 years of age are not covered unless specific rationale is provided indicating the necessity of such treatment.

16. Payment for a denture made with precious metals or an overdenture is based on the allowance for a conventional denture. Payment for flexible base partials is based on the allowance for a resin based partial denture.

17. Specialized procedures performed in conjunction with an overdenture are not covered.

18. Cast unilateral removable partial dentures are not covered benefits.

19. Precision attachments, personalization, precious metal bases and other specialized techniques are not covered benefits.

20. The completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances.

21. Temporary fixed partial dentures are not a covered benefit when done in conjunction with permanent fixed partial dentures and are considered integral to the allowance for the fixed partial dentures.

22. Interim removable partial dentures are a benefit only to replace permanent anterior teeth during the healing period. Interim complete dentures are a benefit only under extenuating circumstances such as jaw or cancer surgery.

23. Repair of temporary appliances is not a covered benefit.

24. A posterior fixed bridge and partial denture in the same arch are not a benefit. Benefit is limited to the allowance for the partial denture.

25. The total allowed fee for repairs including rebases and relines should not exceed half of the allowed amount for a new prosthesis.

26. Fixed partial denture repairs (D6980) are payable by report with documentation of tooth numbers, type of appliance and description of repair.

27. Prosthodontic services are not benefits for patients under age 14 unless specific rationale is provided indicating the necessity of such treatment.

28. Substructures in connection with fixed prosthetics are a benefit once in five years per tooth. Payment for additional procedures is the patient's responsibility.

29. Replacement of a removable prosthesis or fixed prosthesis is covered only if the existing prosthesis was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing prosthesis cannot be made serviceable.

30. Porcelain/ceramic inlays and onlays are not covered benefits. An alternate benefit allowance toward a porcelain/ceramic inlay may be made with a corresponding amalgam restoration on a posterior tooth, and a resin restoration on an anterior tooth. An optional benefit allowance toward a porcelain/ceramic onlay may be made with a metallic onlay.
Any amount greater than the allowance is the patient’s responsibility.

31. Fees for specialized techniques and characterization of dentures are the patient’s responsibility.

**Implant Services**

Coverage: 50% after 12 months
Patient Pays: 50% after 12 months
Subject to Deductible: yes
Applies to Maximum: yes

- **D6010** Surgical placement of implant body: endosteal implant
- **D6013 R** Surgical placement of mini-implant
- **D6050** Surgical placement: transosteal implant
- **D6056** Prefabricated abutment—including modification and placement
- **D6057** Custom fabricated abutment—including placement
- **D6058** Abutment supported porcelain/ceramic crown
- **D6059** Abutment supported porcelain fused to metal crown (high noble metal)
- **D6060** Abutment supported porcelain fused to metal crown (predominantly base metal)
- **D6061** Abutment supported porcelain fused to metal crown (noble metal)
- **D6062** Abutment supported cast metal crown (high noble metal)
- **D6063** Abutment supported cast metal crown (predominantly base metal)
- **D6064** Abutment supported cast metal crown (noble metal)
- **D6065** Implant supported porcelain/ceramic crown
- **D6066** Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- **D6067** Implant supported metal crown (titanium, titanium alloy, high noble metal)
- **D6068** Abutment supported retainer for porcelain/ceramic FPD
- **D6069** Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- **D6070** Abutment supported retainer

for porcelain fused to metal FPD (predominantly base metal)

- **D6071** Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- **D6072** Abutment supported retainer for cast metal FPD (high noble metal)
- **D6073** Abutment supported retainer for cast metal FPD (predominantly base metal)
- **D6074** Abutment supported retainer for cast metal FPD (noble metal)
- **D6075** Implant supported retainer for ceramic FPD
- **D6076** Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
- **D6077** Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
- **D6081** Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure

- **D6090 R** Repair implant supported prosthesis
- **D6094** Abutment supported crown (titanium)
- **D6095 R** Repair implant abutment
- **D6101** Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
- **D6104** Bone graft at time of placement
- **D6110** Implant/abutment supported removable denture for edentulous arch—maxillary
- **D6111** Implant/abutment supported removable denture for edentulous arch—mandibular
- **D6112** Implant/abutment supported removable denture for partially edentulous arch—maxillary
- **D6113** Implant/abutment supported removable denture for partially edentulous arch—mandibular
- **D6114** Implant/abutment supported fixed denture for edentulous arch—mandibular
- **D6115** Implant/abutment supported fixed denture for edentulous arch—mandibular
The following policies apply to implants:

1. Implant services are subject to a 50% cost-share and the annual program maximum.

2. Implant services are not eligible for members under age 14 unless submitted with x-rays and approved by Delta Dental.

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 is presented that demonstrates 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. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

Oral Surgery Services

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D7111  Extraction, coronal remnants—deciduous tooth
D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 X Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220 X Removal of impacted tooth—soft tissue
D7230 X Removal of impacted tooth—partially bony
D7240 X Removal of impacted tooth—completely bony
D7250 X Removal of residual tooth roots (cutting procedure)
D7260  Oraontral fistula closure
D7261  Primary closure of a sinus perforation
D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280  Exposure of an unerupted tooth
D7283  Placement of device to facilitate eruption of impacted tooth
D7285 R Incisional biopsy of oral tissue—hard (bone, tooth)
D7286 R Incisional biopsy of oral tissue—soft
D7290 R Surgical repositioning of teeth
D7291 R Transseptal fiberotomy/supra crestal fiberotomy
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 (maxillary or mandibular)
D7472  Removal of torus palatinus
D7473  Removal of torus mandibularis
D7485  Surgical reduction of osseous tuberosity
D7510  Incision and drainage of abscess—intraoral soft tissue
D7511 R Incision and drainage of abscess—intraoral soft tissue—complicated (includes drainage of multiple fascial spaces)
D7910 R Suture of recent small wounds up to 5 cm
D7911 R Complicated suture—up to 5 cm
D7912 R Complicated suture—greater than 5 cm
D7971  Excision of pericoronal gingiva
D7972  Surgical reduction of fibrous tuberosity
The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.
2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.
3. All hospital costs and any additional fees charged by the dentist arising from procedures rendered in the hospital are the patient’s responsibility.
4. Surgical removal of impactions is payable according to the anatomical position.
5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.
6. The fee for root recovery is included in the treating dentist’s or group practice’s fee for the extraction.
7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.
8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.
9. Excision of pericoronal gingiva is payable once per tooth.
10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.
11. 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.
12. 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.
13. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
14. 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.

Orthodontic Services

Coverage: 50% after 12 months
Patient Pays: 50% after 12 months
Subject to Deductible: No
Applies to Maximum: yes (separate, lifetime maximum)

TRICARE Retiree Dental Program

D8010 R Limited orthodontic treatment of the primary dentition
D8020 R Limited orthodontic treatment of the transitional dentition
D8030 R Limited orthodontic treatment of the adolescent dentition
D8040 R Limited orthodontic treatment of the adult dentition
D8050 R Interceptive orthodontic treatment of the primary dentition
D8060 R Interceptive orthodontic treatment of the transitional dentition
D8070 R Comprehensive orthodontic treatment of the transitional dentition
D8080 R Comprehensive orthodontic treatment of the adolescent dentition
D8090 R Comprehensive orthodontic treatment of the adult dentition
D8210 R Removable appliance therapy
D8220 R Fixed appliance therapy
D8670 R Periodic orthodontic treatment visit
D8680 R Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690 R Orthodontic treatment (alternative billing to a contract fee)

The following policies apply to orthodontic 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 emergency 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 (as part of contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service. Delta Dental uses this code when making periodic payments as part of the complete treatment plan payment.

9. It is the dentist’s and the patient’s responsibility to promptly notify Delta Dental if orthodontic treatment is discontinued or completed sooner than anticipated.

10. Post-operative orthodontic records including radiographs and 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 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.

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.

13. Two cephalometric films (D0340) are payable for orthodontic diagnostic purposes. The fee for additional films taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

General Services

The Enhanced TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

Emergency Services—100% Coverage

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: yes
Applies to Maximum: yes

D0140 Limited oral evaluation—problem-focused

Emergency Services—80% Coverage

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: yes
Applies to Maximum: yes

D9110 Palliative (emergency) treatment of dental pain—minor procedure

The following policies apply to emergency services:

1. Limited oral evaluation—problem-focused (D0140) must involve a problem or symptom that occurred suddenly and unexpectedly and requires immediate attention (emergency). This is paid as an emergency service and payment by Delta Dental is limited to one in a 12-month period for the same dentist. Payment for additional D0140 evaluations in a 12-month period by the same dentist is the responsibility of the patient.

2. Emergency palliative treatment is payable on a per visit basis, once on the same date. All procedures necessary for relief of pain are included.

3. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

Fixed Partial Denture Sectioning

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D9120 R Fixed partial denture sectioning

The following policies apply to fixed partial denture sectioning services:

1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.

3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.
Anesthesia

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D9223  Deep sedation/general anesthesia—each 15 minute increment
D9243  Intravenous moderate (conscious) sedation/analgesia—each 15 minute increment

The following policies apply to anesthesia services:
1. General anesthesia provides coverage by report only and for the administration of anesthesia provided in connection with a covered procedure(s).
2. General anesthesia will be covered only by report and if determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
3. Intravenous sedation will be covered only by report and in conjunction with covered procedures for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
4. Payment is limited to when and if performed by a qualified dentist recognized by the state or jurisdiction in which he/she practices as authorized to perform IV sedation/general anesthesia.

Professional Consultation

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

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

The following policies apply to professional consultation:
1. Consultations reported for a non-covered procedure or condition, such as Temporomandibular Joint Dysfunction, are not covered.

Professional Visits

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes

D9930 R  Treatment of complications (postsurgical), unusual circumstances

Drugs

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D9610 R  Therapeutic parenteral drug, single administration
D9612 R  Therapeutic parenteral drugs, two or more administrations, different medications
D9630 R  Drugs or medicaments dispensed in the office for home use

The following policies apply to coverage of drugs and medications:
1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.
2. The fee for medicaments/solutions is part of the fee for the total procedure.
3. Reimbursement for pharmacy-filled prescriptions is not a benefit.
4. Over-the-counter fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.
5. 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.

Post-Surgical Services

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D9440  Office visits—after regularly scheduled hours

The following policies apply to professional visits:
1. 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.
The following policies apply to post-surgical services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

Miscellaneous Services

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

D9940 R  Occlusal guard
D9941  Fabrication of athletic mouth guard
D9974  Internal bleaching-per tooth

The following policies apply to miscellaneous services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.
2. Occlusal guards are covered for patients over the age of 12 for purposes other than TMJ treatment.
3. Payment for internal bleaching is limited to permanent anterior teeth and when performed in conjunction with root canal therapy.

Exclusions

The following services are not benefits under the Enhanced TRDP. Payment is the patient’s responsibility. Since it is not possible to list all exclusions, it is recommended that if you have questions about your coverage, you should ask your dentist to submit a request for predetermination before your treatment begins.

1. Services for injuries or conditions that are covered under Worker’s Compensation or Employer’s Liability Laws.
2. 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.
3. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.
4. Services for which the member would have no obligation to pay in the absence of this or any similar coverage.
5. Services performed prior to the member’s effective coverage date.
6. Services incurred after the termination date of the member’s coverage unless otherwise indicated.
7. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.
8. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
9. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
10. Prescribed or applied therapeutic drugs, premedication, sedation, or analgesia.
11. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.
12. Services which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.
13. Services not meeting accepted standards of dental practice.
14. Services which are for unusual procedures and techniques.
15. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
16. Plaque control programs, oral hygiene instruction, and dietary instruction.
17. 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 malalignment of teeth.
18. Gold foil restorations.
19. Premedication and inhalation analgesia.
20. House calls and hospital visits.
21. Telephone consultations.
22. Services performed by a dentist who is compensated by a facility for similar covered services performed for members.
23. Services resulting from the patient’s failure to comply with professionally prescribed treatment.
24. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.
25. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
26. Duplicate and temporary devices, appliances, and services.
27. Experimental procedures.
28. All hospital costs and any additional fees charged by the dentist for hospital treatment.
29. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
30. Removal of implants.
31. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
32. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.
33. Treatment for routine dental services provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada when the enrollee is traveling overseas. An exception is made for full-time students studying overseas and for enrollees who live permanently overseas.
34. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.
35. Procedures not specifically listed are not payable, other than those modified by Delta Dental or those toward which an alternate benefit is provided by the program and as defined within the benefit policies.
36. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.

Basic Program — Policies, Covered Benefits, Limitations and Exclusions

General Policies
1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (non-covered services) for billing purposes.
2. Claims received on or after the first of the month following 12 months of the date of service are not payable by Delta Dental. The fees for Delta Dental’s portion of the payment are not chargeable to the patient by a participating network dentist.
3. Participating dentists must agree not to charge the patient more than the deductible and/or cost-share amount as shown on the Explanation of Benefits.
4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.
5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.
6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).
7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.
8. Postoperative care and evaluation are included in the fee for the service.
9. The fee for medicaments/solutions is part of the fee for the total procedure.
10. Procedure codes may be modified by Delta Dental based on the description of service and submitted supporting documentation.
11. For procedures limited to a certain frequency during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.
12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.
13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient’s responsibility.
14. Covered procedures are payable only upon completion of the procedure billed.
15. Services must be necessary 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 his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.

16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.

17. Effective July 1, 2007, the TRICARE medical plan implemented coverage for medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for pediatric patients age 5 and under (this general anesthesia benefit is not covered by the TRDP). Since preauthorization for this benefit is required, patients should contact their regional TRICARE Managed Care Support Contractor for specific instructions. Information is also available at www.tricare.mil.

18. An “R” to the right of the procedure code means “by report” and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits.

19. An “X” to the right of the procedure code means that these services will be paid only when a current radiograph is submitted with the dental claim.

**Diagnostic Services**

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with a primary caregiver</td>
</tr>
<tr>
<td>D0150 R</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation—limited, problem-focused (established patient; not post-operative visit)</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
</tr>
</tbody>
</table>

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.
2. Payment is limited to any two evaluations, comprehensive and/or periodic, in a 12-month period. Payment for more than two evaluations, comprehensive and/or periodic, in a 12-month period is the patient’s responsibility. This limitation includes procedure D0145, “Oral evaluation for a patient under three years of age and counseling with a primary caregiver.”
3. One comprehensive oral evaluation (D0150 - comprehensive oral evaluation, D0160 - detailed and extensive oral evaluation or D0180 - comprehensive periodontal evaluation) is payable once per dentist per year and only if related to covered dental procedures. Additional evaluations are considered periodic evaluations and are paid as such.
4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.
5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.
6. Examinations/evaluations by specialists are payable as comprehensive or periodic.
examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.

7. 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.

8. 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.

9. If the total fee for individually listed radiograph images equals or exceeds the fee for a complete series, these radiograph images are paid as a complete series and are subject to the same benefit limitations.

10. 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 is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional radiographic images.

11. Payment for panoramic radiographic image is limited to one within a 48-month period.

12. Payment for periapical radiographic images (other than as part of a full-mouth series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.

13. 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.

14. Radiograph images of non-diagnostic quality are not payable.

15. Duplication of radiographic images for administrative purposes is not payable.

16. Test reports must describe the pathological condition, type of study and rationale.

17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.

18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

19. Detailed and extensive oral evaluations (D0160) are limited to once per patient per dentist, per lifetime. They will not be paid if related to non-covered medical or dental procedures.

20. Re-evaluations (D0170) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to non-covered medical or dental procedures.

Preventive Services—100% Coverage

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

- D1110 Prophylaxis—adult (one per 12-month period)
- D1120 Prophylaxis—child (two per 12-month period)
- D1206 Topical application of fluoride varnish
- D1208 Topical application of fluoride—excluding varnish

Preventive Services—80% Coverage

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: Yes
Applies to Maximum: Yes

- D1351 Sealant—per tooth
- D1510 Space maintainer—fixed - unilateral
- D1515 Space maintainer—fixed - bilateral
- D1520 Space maintainer—removable - unilateral
- D1525 Space maintainer—removable - bilateral
- D1550 Re-cement or re-bond space maintainer
- D1555 Removal of fixed space maintainer
- D1575 Distal shoe space maintainer—fixed—unilateral

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.

2. One prophylaxis for adults is covered in a period of 12 consecutive months to the day. This limitation includes periodontal procedures D4346 or D4910, which are covered at 60%. Payment is limited to one prophylaxis or one periodontal procedure in 12 consecutive months to the day. Payment for additional prophylaxes or periodontal procedures is the patient’s responsibility.

3. Two prophylaxes for children are covered in a period of 12 consecutive months to the day.
4. One fluoride treatment for adults and two fluoride treatments for children are covered in a period of 12 consecutive months. This limitation includes procedure D1206, “topical application of fluoride varnish.” Payment for additional fluoride treatments are the patient’s responsibility.

5. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.

6. 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.

7. 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.

8. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.

9. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

The following policies apply to preventive services covered at 80%:

10. Sealants are only covered on permanent molars through age 18.

11. One sealant per tooth is covered in a three-year period.

12. Sealants are only payable for molars that are caries free with no previous restorations on the mesial, distal or occlusal surfaces.

13. Sealants for teeth other than permanent molars are not covered.

14. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.

15. 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.

16. The tooth number of the space to be maintained is required when requesting payment for space maintainers.

17. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.

18. The fee for a space maintainer-type appliance done in conjunction with orthodontic treatment is not covered.

19. 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).

20. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.

21. Repair of a damaged space maintainer is not covered.

22. Recementation of space maintainers is payable once within 12 months.

23. Space maintainers are not covered for patients 14 years and older.

24. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by contractor or chargeable to the patient by a participating network dentist.

25. Distal shoe space maintainer is a benefit to guide the eruption of the first permanent molar and is not covered for patients 14 years and older.

Restorative Services

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: Yes
Applies to Maximum: Yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
</tbody>
</table>
The following policies apply to restorative services:

1. Coverage is for basic restorative services of amalgam fillings and anterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.

2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.

3. Replacement of a restoration by the same dentist or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.

4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents, gingivectomy, infection control and expenses for compliance with OSHA regulations, etc., is not payable.

5. 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.

6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review.

7. Posterior restorations not involving the occlusal surface are paid as one surface restorations, subject to review.

8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.

9. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.

10. Pin retention is payable once per restoration to the same dentist or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.

11. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 24 months is not covered.

12. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.

13. Pin retention and buildups on primary teeth are covered in the fee for the restoration.

14. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.

15. Recementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.

16. After six months from the initial cementation date, recementation of crowns is payable once within 12 months.

17. Composite resin restorations on posterior teeth are not covered procedures and payment is the patient’s responsibility.

**Endodontic Services**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3120</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—</td>
</tr>
</tbody>
</table>
The following policies apply to endodontic services:

1. 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.

2. An indirect pulp cap is only payable once per tooth by the same dentist.

3. A direct pulp cap is included in the fee for the restoration or palliative treatment.

4. 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.

5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.

6. Endodontic procedures in conjunction with overdentures are not covered benefits.

7. The completion date for endodontic therapy is the date the tooth is sealed.

8. 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.

9. 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.

10. 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.

11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.

12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.

13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed with codes D3310 – D3330, D3346 – D3348, or D3351 – D3353 on the same day or within 30 days (same tooth/same provider/same office).

**Periodontic Services**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D4210 R Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-
bounded spaces per quadrant

D4211 R Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant

D4240 R Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant

D4241 R Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant

D4245 R Apically positioned flap

D4260 R Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant

D4261 R Osseous surgery (including flap entry and closure)—one to three contiguous teeth or tooth-bounded spaces per quadrant

D4263 R Bone replacement graft—retained natural tooth—first site in quadrant

D4264 R Bone replacement graft—retained natural tooth—each additional site in quadrant

D4266 R Guided tissue regeneration—resorbable barrier, per site

D4267 R Guided tissue regeneration—non-resorbable barrier, per site (includes membrane removal)

D4270 R Pedicle soft tissue graft procedure

D4273 R Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position

D4277 R Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft

D4278 R 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 R Autogenous connective tissue graft procedure (including donor and recipient surgical sites) —each additional contiguous tooth, implant or edentulous tooth position in same graft site

D4341 R Periodontal scaling and root planing—four or more teeth per quadrant

D4342 R Periodontal scaling and root planing—one to three teeth per quadrant

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

D4355 R Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis

D4910 Periodontal maintenance

D4920 R Unscheduled dressing change (by someone other than treating dentist)

The following policies apply to 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/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.

3. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.

4. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.

5. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.

6. Bone grafts, soft tissue grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of natural teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, existing implants or other non-periodontal surgical procedures.

7. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

8. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.
9. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same dentist.

10. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery, periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation.

11. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.

12. An apically positioned flap is subject to documentation when performed and when not related to implants.

13. Full-mouth debridement is payable once per lifetime per patient.

14. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II or greater periodontal disease. All procedures must be completed within 90 days.

Oral Surgery Services

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D7111  Extraction, coronal remnants—deciduous tooth
D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 X Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220 X Removal of impacted tooth—soft tissue
D7230 X Removal of impacted tooth—partially bony
D7240 X Removal of impacted tooth—completely bony
D7250 X Removal of residual tooth roots (cutting procedure)
D7260  Oroantral fistula closure
D7261  Primary closure of a sinus perforation
D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7280  Exposure of an unerupted tooth
D7285 R Incisional biopsy of oral tissue—hard (bone, tooth)
D7286 R Incisional biopsy of oral tissue—soft
D7290 R Surgical repositioning of teeth
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
D7910  Suture of recent small wounds up to 5 cm
D7911  Complicated suture—up to 5 cm
D7912 R Complicated suture—greater than 5 cm
D7971  Excision of pericoronal gingiva

The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.

2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.

3. All hospital costs and any additional fees charged by the provider arising from procedures rendered in the hospital are the patient’s responsibility.

4. Surgical removal of impactions is payable according to the anatomical position.

5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.

6. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.

7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.

8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.

9. Excision of pericoronal gingiva is payable once per tooth.

10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.

11. 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.

12. 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.

**Adjunctive General Services**

The Basic TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

**Emergency Services—100% coverage**

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: Yes
Applies to Maximum: Yes

D0140 Limited oral evaluation—problem-focused

**Emergency Services—80% coverage**

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9110 Palliative (emergency) treatment of dental pain—minor procedure

**The following policies apply to emergency services:**

1. Limited oral evaluation—problem-focused (D0140) must involve a problem or symptom that occurred suddenly and unexpectedly and requires immediate attention (emergency). This is paid as an emergency service and payment by Delta Dental is limited to one in a 12-month period for the same dentist. A limited oral evaluation does not count as one of the two evaluations, comprehensive and/or periodic, allowed in a 12-month period. Payment for additional D0140 evaluations in a 12-month period by the same dentist are the responsibility of the patient.

2. Emergency palliative treatment is payable on a per-visit basis, once on the same date. All procedures necessary for relief of pain are included.

3. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

**Fixed Partial Denture Sectioning**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9120 Fixed partial denture sectioning

**The following policies apply to fixed partial denture sectioning services:**

1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.

3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.

**Drugs**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9610 R Therapeutic parenteral drug, single administration

D9612 R Therapeutic parenteral drugs, two or more administrations, different medications

D9630 R Drugs or medicaments dispensed in the office for home use

**The following policies apply to coverage of drugs and medications:**

1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.

2. The fee for medicaments/solutions is part of the fee for the total procedure.

3. Reimbursement for pharmacy-filled prescriptions is not a benefit.

4. Fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.
5. 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.

**Post-Surgical Services**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9930 Treatment of complications (post-surgical), unusual circumstances

The following policy applies to post-surgical services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

**Exclusions**

Procedures that are covered under the Basic TRDP are listed above. The following services are not benefits under the Basic TRDP:

1. Procedures not specifically listed are not payable, other than those modified by Delta Dental or those toward which an alternate benefit is provided by the program and as defined within the benefits policies.
2. Services for injuries or conditions that are covered under Worker’s Compensation or Employer’s Liability Laws.
3. 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.
4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.
5. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
6. Those performed prior to the member’s effective coverage date.
7. Those incurred after the termination date of the member’s coverage unless otherwise indicated.

8. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.
9. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
10. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
11. Prescribed or applied therapeutic drugs, premedication, sedation, analgesia and general anesthesia.
12. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.
13. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.
14. Those not meeting accepted standards of dental practice.
15. Those which are for unusual procedures and techniques.
16. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. Plaque control programs, oral hygiene instruction, and dietary instruction.
18. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting and full-mouth rehabilitation.
20. Premedication and inhalation analgesia.
22. Experimental procedures.
23. Telephone consultations.
24. Those performed by a provider who is compensated by a facility for similar covered services performed for members.
25. Those resulting from the patient’s failure to comply with professionally prescribed treatment.
26. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.

27. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.

28. Duplicate and temporary devices, appliances and services.

28. All hospital costs and any additional fees charged by the dentist for hospital treatment.

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

30. Implants (materials implanted into or on bone or soft tissue), maintenance of implants or the removal of implants.

31. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

32. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.

33. Orthodontic services.

34. Prosthodontic services.

35. Cast crowns, inlays, onlays or partial crowns.

36. Treatment provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada.

37. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.

38. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.
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.

**NEW Benefits for 2017**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1575</td>
<td>Distal shoe maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation</td>
</tr>
</tbody>
</table>
### Summary of Benefits

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Plan Summary of Benefits by Network Percentage</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Standard Plan</td>
<td>High Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td>Basic Services — Class A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic</td>
<td>100%</td>
<td>60%</td>
<td>100%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>100%</td>
<td>60%</td>
<td>100%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Intermediate Services — Class B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Restorative</td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Endodontic</td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Periodontic</td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Major Services — Class C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td>35%</td>
<td>20%</td>
<td>50%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Endodontic</td>
<td>35%</td>
<td>20%</td>
<td>50%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Periodontic</td>
<td>35%</td>
<td>20%</td>
<td>50%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>35%</td>
<td>20%</td>
<td>50%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services — Class D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(children under age 19)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>General Services</td>
<td></td>
<td>55%</td>
<td>40%</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$75</td>
<td>$0</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,500</td>
<td>$600</td>
<td>$4,000</td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Maximum</td>
<td>$2,000</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Waiting Period</td>
<td>12 months</td>
<td>12 months</td>
<td>12 months</td>
<td>12 months</td>
<td></td>
</tr>
</tbody>
</table>
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.

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 $4,000 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 $4,000 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

<table>
<thead>
<tr>
<th>Class</th>
<th>Plan Option</th>
<th>High Plan Option</th>
<th>Standard Plan Option</th>
<th>Diagnostic Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network: 100% for covered services as defined by the plan and subject to plan deductibles and maximums.</td>
<td>In-Network: 100% for covered services as defined by the plan subject to plan deductibles and maximums.</td>
<td>D0120 Periodic oral evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td>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.</td>
<td>D0140 Limited oral evaluation—problem focused</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0150 Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0180 Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0210 Intraoral—complete set of radiographic images including bitewings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0220 Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0230 Intraoral—periapical—each additional radiographic image</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0240 Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0250 Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0251 Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0273 Bitewings—three radiographic images</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0274 Bitewings—four radiographic images</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0277 Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0277 Panoramic radiographic image</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D0425 Caries susceptibility tests</td>
</tr>
</tbody>
</table>

Preventive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—Adult</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—Child</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride—excluding varnish</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant – per tooth</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in a moderate to high caries risk patient – permanent tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Recementation of space maintainer</td>
</tr>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain —minor procedure</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class B – Intermediate Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Plan Option</td>
</tr>
<tr>
<td>In-Network: 70% of the plan allowance for covered services as defined by the plan and subject to plan deductible and maximum, per person.</td>
</tr>
</tbody>
</table>
• **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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite — one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite—two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite—three surfaces, posterior</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite—four or more surfaces, posterior</td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown—primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown—permanent tooth</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention—per tooth, in addition to restoration</td>
</tr>
</tbody>
</table>

**Endodontic Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap - direct (excluding final restoration)</td>
</tr>
<tr>
<td>D3120</td>
<td>Pulp cap - indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
</tbody>
</table>

**Periodontic Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing—four or more teeth per quadrant</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing—one to three teeth, per quadrant</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
</tr>
<tr>
<td>D7921</td>
<td>Collection and application of autologous blood concentrate product</td>
</tr>
</tbody>
</table>

**Prosthodontic Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture—maxillary</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture—mandibular</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture—maxillary</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture—mandibular</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth—complete denture (each tooth)</td>
</tr>
</tbody>
</table>

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”
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth—per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture—per tooth</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
</tr>
<tr>
<td>D5850</td>
<td>Tissue conditioning (maxillary)</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning (mandibular)</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement fixed partial denture</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth—completely bony</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth—completely bony, with unusual surgical complications</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>D7251</td>
<td>Coronectomy - intentional partial tooth removal</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveolography in conjunction with extractions – four or more teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveolography in conjunction with extractions – one to three teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveolography not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveolography not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess—extraoral soft tissue</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
</tr>
<tr>
<td>D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
</tr>
</tbody>
</table>

### Oral Surgery Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants—deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth—soft tissue</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth—partially bony</td>
</tr>
</tbody>
</table>

### 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.
subject to plan deductible and maximum, per person.

### Major Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation – problem focused, by report</td>
</tr>
<tr>
<td>D2510</td>
<td>Inlay – metallic – one surface</td>
</tr>
<tr>
<td>D2520</td>
<td>Inlay – metallic – two surfaces</td>
</tr>
<tr>
<td>D2530</td>
<td>Inlay – metallic – three surfaces</td>
</tr>
<tr>
<td>D2542</td>
<td>Onlay – metallic – two surfaces</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay – metallic – three surfaces</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay – metallic – four or more surfaces</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown – porcelain/ceramic substrate</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown – porcelain fused to predominately base metal</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown – 3/4 cast high noble metal</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown – 3/4 cast predominately base metal</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown – 3/4 cast noble metal</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown – 3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown – full cast high noble metal</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown – full cast predominately base metal</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown – full cast noble metal</td>
</tr>
<tr>
<td>D2794</td>
<td>Crown – titanium</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core, in addition to crown</td>
</tr>
<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2981</td>
<td>Inlay repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2983</td>
<td>Veneer repair necessitated by restorative material failure</td>
</tr>
<tr>
<td>D2990</td>
<td>Resin infiltration of incipient smooth surface lesions</td>
</tr>
</tbody>
</table>

### Endodontic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar (excluding final restoration)</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy – anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy – bicuspid</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification – interim medication replacement</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy – anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy – bicuspid (first root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy (each additional root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling – per root</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation – per root</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection (including any root removal), not including root canal therapy</td>
</tr>
</tbody>
</table>

### Periodontal Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant per quadrant</td>
</tr>
<tr>
<td>D4212</td>
<td>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
</tr>
</tbody>
</table>

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”
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening – hard tissue</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position</td>
</tr>
<tr>
<td>D4275</td>
<td>Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined connective tissue and double pedicle graft, per tooth</td>
</tr>
<tr>
<td>D4277</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4278</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous connective tissue graft procedure (including donor and surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4285</td>
<td>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</td>
</tr>
<tr>
<td>D4355</td>
<td>Full-mouth debridement to enable comprehensive evaluation and diagnosis</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of antimicrobial agents via a controlled release vehicle into diseases crevicular tissue, per tooth</td>
</tr>
</tbody>
</table>

### Prosthodontic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture – maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture – mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture – maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture – mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5281</td>
<td>Removable unilateral partial denture - one piece cast metal (including clasps and teeth)</td>
</tr>
<tr>
<td>D6010</td>
<td>Surgical placement of implant body: endosteal implant</td>
</tr>
<tr>
<td>D6013</td>
<td>Surgical placement of mini implant</td>
</tr>
<tr>
<td>D6055</td>
<td>Connecting Bar - implant supported or abutment supported</td>
</tr>
<tr>
<td>D6056</td>
<td>Prefabricated abutment – includes placement</td>
</tr>
<tr>
<td>D6057</td>
<td>Custom fabricated abutment – includes placement</td>
</tr>
<tr>
<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown</td>
</tr>
</tbody>
</table>
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for porcelain fused metal FPD (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments

D6090 Repair implant supported prosthesis, by report
D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6094 Abutment supported crown (titanium)
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
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
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
Federal Employees Dental Program

Class D — Orthodontic Services

High 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 lifetime maximum of $2,000. 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 $1,000. 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

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

- D9223 Deep sedation/general anesthesia – each 15 minute increment
- D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment

Consultations

- D9310 Consultation – diagnostic service
Office Visits

D9440  Office visit – after regular scheduled hours

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

Miscellaneous Services

D9940  Occlusal guard, by report
D9941  Fabrication of athletic mouthguard
D9974  Internal bleaching – per tooth

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. All dental services (exclusive of orthodontia) will have an annual maximum benefit of $1500 per year or greater (in network).

Benefits and Limitations for Diagnostic Services

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a 12-consecutive-month period.

2. One comprehensive evaluation (D0150) is allowed in a 12-consecutive-month period.

3. One limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-consecutive-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-12-months 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 12-month period 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 12-consecutive-month period to the day.

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 12-consecutive-month period.

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.

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.
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, 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.
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 pulp 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 24 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 or scaling and root planing in the same area of the mouth within 24 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 24 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.

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 12-month period to the day.

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.
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. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.

13. 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.

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 reline/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 reline/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 by report for patients 13 years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one per 12-consecutive-month period.

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 Myofacial 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, 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.
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).

**NEW Benefits for 2017**

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<thead>
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<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation*</td>
</tr>
</tbody>
</table>

*Applicable to Enhanced and Comprehensive Plans only
## Summary of Benefits

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Plan Summary of Benefits by Network Percentage</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard</td>
<td>Enhanced</td>
<td>Comprehensive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td></td>
<td>Year 1+</td>
<td>Year 1</td>
<td>Year 2+</td>
<td>Year 1</td>
</tr>
<tr>
<td>Diagnostic¹</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Preventive¹</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>50%</td>
<td>30%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Major Restorative²</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
</tr>
<tr>
<td>Endodontics²</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontics²</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery²⁻³</td>
<td>50%</td>
<td>30%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Prosthodontics²</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
</tr>
<tr>
<td>General Services</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
<td>NAB</td>
</tr>
<tr>
<td>Deductible</td>
<td>$50</td>
<td>$50</td>
<td>$50¹</td>
<td>$50¹</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$500</td>
<td>$500</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

NAB = Not a Benefit

¹ The deductible is waived for diagnostic and preventive services under the Enhanced plan. Under the Comprehensive plan the deductible is waived for diagnostic and preventive services provided out-of-network, and there is no deductible for any services provided in-network.

² Enhanced plan: The waiting period is twelve (12) months for endodontics and periodontics. Comprehensive plan: The waiting period is 12 months for major restorative, endodontics, periodontics, oral surgery² and prosthodontics.

³ Simple extractions (procedure codes D7111 and D7140) are the only oral surgery services covered under the Standard and Enhanced plans, and the only services covered in the first 12 months under the Comprehensive plan.
Comprehensive Plan – Policies, Covered Benefits, Limitations and Exclusions

### Diagnostic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation—problem focused</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation—problem focused, by report</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
</tr>
</tbody>
</table>

### Policy Limitations for Diagnostic Services

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a 12-consecutive-month period. 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 12-consecutive-month period.

3. Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-consecutive-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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—child</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride—excluding varnish</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>

### Policy Limitations for Preventive Services

1. Two routine prophylaxes are covered in a 12-consecutive-month period to the day.

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. 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 12-consecutive-month period.
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite—one surface, posterior</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite—two surfaces, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite—three surfaces, posterior</td>
</tr>
</tbody>
</table>

### Major Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2394</td>
<td>Resin-based composite—four or more surfaces, posterior</td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown—primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown—permanent tooth</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention—per tooth, in addition to restoration</td>
</tr>
</tbody>
</table>

### Veterans Affairs Dental Insurance Program

- **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

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**Veterans Affairs Dental Insurance Program**

**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)
- **D2390**: Resin-based composite—one surface, posterior
- **D2391**: Resin-based composite—two surfaces, posterior
- **D2392**: Resin-based composite—three surfaces, posterior

---

**Veterans Affairs Dental Insurance Program**

**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 substrate
- **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—¾ cast high noble metal
- **D2781**: Crown—¾ cast predominantly base metal
- **D2782**: Crown—¾ cast noble metal
- **D2783**: Crown—¾ porcelain/ceramic
- **D2790**: Crown—full-cast high noble metal
- **D2791**: Crown—full-cast predominantly base metal
- **D2792**: Crown—full-cast 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
- **D2990**: Resin infiltration of incipient smooth surface lesions—limited to permanent molars through age 15
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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap—direct (excluding final restoration)</td>
</tr>
<tr>
<td>D3120</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy—anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy—bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy—molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification—interim medication replacement</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification—final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy—anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy—bicuspид (first root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery—molar (first root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy (each additional root)</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling—per root</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation—per root</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection (including any root removal), not including root canal therapy</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4212</td>
<td>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
</tbody>
</table>
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 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
D4341  Periodontal scaling and root planing—four or more contiguous teeth or tooth-bounded spaces 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 evaluation and diagnosis
D4381  Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910  Periodontal maintenance
D7921  Collection and application of autologous blood concentrate product

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 24 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 24 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 24 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.

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 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 (code D4355) is covered once per lifetime.

Prosthodontic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture—maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture—mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture—maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture—mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5281</td>
<td>Removable unilateral partial denture—one-piece cast metal (including clasps and teeth)</td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust complete denture—maxillary</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture—mandibular</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture—maxillary</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture—mandibular</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth—complete denture (each tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp—per tooth</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth—per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture—per tooth</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
</tr>
</tbody>
</table>
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
D6010 Surgical placement of implant body: endosteal implant
D6013 Surgical placement of mini-implant
D6055 Connecting bar—implant supported or abutment supported
D6056 Prefabricated abutment—including modification and placement
D6057 Custom fabricated abutment—including placement
D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6080 Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6090 Repair implant supported prosthesis by report
D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6094 Abutment supported crown (titanium)
D6100 Implant removal, by report
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
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 predominantly base metal
D6751 Retainer crown—porcelain fused to high noble metal
D6752 Retainer crown—porcelain fused to noble metal
D6780 Retainer crown—¼ cast high noble metal
D6781 Retainer crown—¾ cast predominantly base metal
D6782 Retainer crown—¼ cast noble metal
D6783 Retainer crown—¾ 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 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—deciduous 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 re-implantation 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 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.

General Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain—minor procedure</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia—each 15 minute increment</td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation—diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit—after regularly scheduled hours</td>
</tr>
<tr>
<td>D9610</td>
<td>Therapeutic parenteral drug, single administration</td>
</tr>
<tr>
<td>D9612</td>
<td>Therapeutic parenteral drugs, two or more administrations, different medications</td>
</tr>
<tr>
<td>D9930</td>
<td>Treatment of complications (post-surgical)—unusual circumstances, by report</td>
</tr>
<tr>
<td>D9940</td>
<td>Occlusal guard, by report</td>
</tr>
<tr>
<td>D9941</td>
<td>Fabrication of athletic mouth guard</td>
</tr>
<tr>
<td>D9974</td>
<td>Internal bleaching—per tooth</td>
</tr>
<tr>
<td>D9999</td>
<td>Unspecified adjunctive procedure, by report</td>
</tr>
</tbody>
</table>

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 by report for patients 13 years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one per 12-consecutive-month period.

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.

**Enhanced Plan – Policies, Covered Benefits, Limitations and Exclusions**

### Diagnostic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
</tr>
</tbody>
</table>

### Policy Limitations for Diagnostic Services

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a 12-consecutive-month period. 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 (1) comprehensive evaluation (D0150) will be allowed in a 12-consecutive-month period.

3. Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-consecutive-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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—child</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride—excluding varnish</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>

### Policy Limitations for Preventive Services

1. Two routine prophylaxes are covered in a 12-consecutive-month period to the day.

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. 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 12-consecutive-month period.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite—one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite—two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite—three surfaces, posterior</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite—four or more surfaces, posterior</td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown—primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown—permanent tooth</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention—per tooth, in addition to restoration</td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap—direct (excluding final restoration)</td>
</tr>
<tr>
<td>D3120</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy—anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy—bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy—molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification—interim medication replacement</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification—final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy—bicuspid (first root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy—molar (first root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling—per root</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation—per root</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection (including any root removal), not including root canal therapy</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4212</td>
<td>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening—hard tissue</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure)—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position</td>
</tr>
<tr>
<td>D4275</td>
<td>Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined connective tissue and double pedicle graft, per tooth</td>
</tr>
<tr>
<td>D4277</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4278</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous connective tissue graft procedure (including donor and recipient surgical sites)—each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4285</td>
<td>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</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing—four or more teeth per quadrant</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing—one to three teeth per quadrant</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation</td>
</tr>
<tr>
<td>D4355</td>
<td>Full-mouth debridement to enable comprehensive evaluation and diagnosis</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
</tr>
<tr>
<td>D7921</td>
<td>Collection and application of autologous blood concentrate product</td>
</tr>
</tbody>
</table>

**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 24 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 24 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 24 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.

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 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 (code D4355) is covered once per lifetime.

**Oral Surgery Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants—deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
</tr>
</tbody>
</table>

**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.

**Standard Plan — Policies, Covered Benefits, Limitations and Exclusions**

**Diagnostic Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D project radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings—seven to eight radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
</tr>
</tbody>
</table>

**Policy Limitations for Diagnostic Services**

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a 12-consecutive-month period. 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 12-consecutive-month period.

3. Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-consecutive-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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—child</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride—excluding varnish</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>

**Policy Limitations for Preventive Services**

1. Two routine prophylaxes are covered in a 12-consecutive-month period to the day.

2. Routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.

3. 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.
4. Two topical fluoride applications are covered in a 12-consecutive-month period.
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam—one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam—two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam—three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam—four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite—one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite—two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite—three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite—four or more surfaces or involving incisal angle (anterior)</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite—one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite—two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite—three surfaces, posterior</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite—four or more surfaces, posterior</td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown—primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown—permanent tooth</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention—per tooth, in addition to restoration</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery without apicoectomy</td>
</tr>
</tbody>
</table>

### 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 crown.  

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, 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.  

Oral Surgery Services  

D7111 Extraction, coronal remnants—deciduous 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.
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.
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.

**NEW Benefits for 2017**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation</td>
</tr>
</tbody>
</table>

**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 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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan Pays</td>
<td>Enrollee Pays</td>
</tr>
<tr>
<td><strong>Class I: Diagnostic, Preventive and Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral Exams; full-mouth, bitewing, panoramic and periapical x-rays</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>• Routine cleansings, fluoride application, sealants, space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Palliative (emergency) care to relieve pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Class II: Basic Restorative Care, Endodontics, Periodontics, Prosthodontics, Oral Surgery and Anesthesia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fillings</td>
<td>80%*</td>
<td>20%*</td>
</tr>
<tr>
<td>• Root canal therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Osseous surgery, periodontal scaling and root planing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental adjustments and repairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia (deep sedation/general, IV moderate (conscious) sedation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Class III</strong>*: Major Restorative Care, Implants and Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crowns, inlays, and onlays</td>
<td>60%*</td>
<td>40%*</td>
</tr>
<tr>
<td>• Surgical Implants, implant crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dentures, bridges and partials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Class IV: Orthodontia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Coverage for children and adults</td>
<td>60%*</td>
<td>40%*</td>
</tr>
</tbody>
</table>

**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**
  - $50 per person
- **Family**
  - $150 per family

**Orthodontic Lifetime Maximum**

- $2,000 for children and adults

* Subject to annual deductible
** Non-Delta Dental, non-contracted dentists (out-of-network dentists) are paid based on usual and customary charges.
*** Missing tooth limitation: Replacement of a missing tooth is covered under Class III benefits; however, a 24-month coverage imitation 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:
$50.00 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
D1515 Space maintainer – fixed, bilateral
D1520 Space maintainer – removable, unilateral
D1525 Space maintainer – removable, bilateral
D1550 Re-cement or re-bond space maintainer
D1575 Distal shoe space maintainer—fixed—unilateral
### Adjunctive General Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain - minor procedure</td>
</tr>
</tbody>
</table>

### Class II

### Basic Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam – one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam – two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam – three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam – four or more surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite – one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite – two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite – three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite – four or more surfaces or involving incisel angle</td>
</tr>
<tr>
<td></td>
<td>(anterior)</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite – one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite – two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite – three surfaces, posterior</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite – four or more surfaces, posterior</td>
</tr>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</td>
</tr>
<tr>
<td>D2915</td>
<td>Re-cement or re-bond indirectly fabricated or prefabricated post and core</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown – primary tooth</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown – permanent tooth</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention – per tooth, in addition to restoration</td>
</tr>
</tbody>
</table>

### Endodontics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap – direct (excluding final restoration)</td>
</tr>
<tr>
<td>D3120</td>
<td>Pulp cap – indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis - permanent tooth with incomplete root</td>
</tr>
<tr>
<td></td>
<td>development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding</td>
</tr>
<tr>
<td></td>
<td>final restoration</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding</td>
</tr>
<tr>
<td></td>
<td>final restoration</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar (excluding final restoration)</td>
</tr>
<tr>
<td>D3340</td>
<td>Endodontic therapy, molar (excluding final restoration)</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy – anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy – bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy – molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification – initial visit (apical closure/calcific</td>
</tr>
<tr>
<td></td>
<td>repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification – interim medication replacement</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification – final visit (includes completed root canal</td>
</tr>
<tr>
<td></td>
<td>therapy – apical closure/calcific repair of perforations, root resorption,</td>
</tr>
<tr>
<td></td>
<td>etc.)</td>
</tr>
<tr>
<td>D3355</td>
<td>Pulpal regeneration – initial visit</td>
</tr>
<tr>
<td>D3356</td>
<td>Pulpal regeneration – interim medication replacement</td>
</tr>
<tr>
<td>D3357</td>
<td>Pulpal regeneration – completion of treatment</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy – anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy surgery – bicuspid (first root)</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy – molar (first root)</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy – (each additional root)</td>
</tr>
</tbody>
</table>
### Periodontic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3430</td>
<td>Retrograde filling - per root</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation – per root</td>
</tr>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4212</td>
<td>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing – four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing – one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening - hard tissue</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full-thickness flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full-thickness flap and closure) – one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position</td>
</tr>
<tr>
<td>D4275</td>
<td>Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined connective tissue and double pedicle graft, per tooth</td>
</tr>
<tr>
<td>D4277</td>
<td>Free soft tissue graft (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft</td>
</tr>
<tr>
<td>D4278</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous connective tissue graft procedures (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4285</td>
<td>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</td>
</tr>
<tr>
<td>D4310</td>
<td>Periodontal scaling and root planing – four or more teeth per quadrant</td>
</tr>
<tr>
<td>D4311</td>
<td>Periodontal scaling and root planing – one to three teeth per quadrant</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
</tr>
<tr>
<td>D7921</td>
<td>Collection and application of autologous blood concentrate product</td>
</tr>
</tbody>
</table>

### Prosthodontic Services - Removable

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture – maxillary</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture – mandibular</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture – maxillary</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture – mandibular</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth – complete denture (each tooth)</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp – per tooth</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth – per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture – per tooth</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast</td>
</tr>
</tbody>
</table>
### Oral Surgery Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
</tr>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>D7251</td>
<td>Coronectomy - intentional partial tooth removal</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloplasty no in conjunction with extraction - one to three teeth or tooth spaces, per quadrant</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronar gingiva</td>
</tr>
<tr>
<td>D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
</tr>
</tbody>
</table>

### Adjunctive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia - each 15 minute increments</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment</td>
</tr>
</tbody>
</table>

### Class III Diagnostic Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem-focused, by report</td>
</tr>
</tbody>
</table>

### Major Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510</td>
<td>Inlay - metallic, one surface</td>
</tr>
<tr>
<td>D2520</td>
<td>Inlay - metallic, two surfaces</td>
</tr>
<tr>
<td>D2530</td>
<td>Inlay - metallic, three or more surfaces</td>
</tr>
<tr>
<td>D2542</td>
<td>Onlay - metallic, two surfaces</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay - metallic, three surfaces</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay - metallic, four or more surfaces</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high-noble metal</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - ¾ cast high-noble metal</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown - ¾ cast predominantly base metal</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown - ¾ cast noble metal</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - ¾ porcelain/ceramic</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high-noble metal</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown - full cast predominantly base metal</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown - full cast noble metal</td>
</tr>
<tr>
<td>D2794</td>
<td>Crown - titanium</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
</tr>
</tbody>
</table>
Crown repair necessitated by restorative material failure
Inlay repair necessitated by restorative material failure
Onlay repair necessitated by restorative material failure
Veneer repair necessitated by restorative material failure
Resin infiltration of incipient smooth surface lesions

**Implants**

- **D6010** Surgical placement of implant body: endosteal implant
- **D6055** Connecting bar – implant supported or abutment supported
- **D6056** Prefabricated abutment – includes modification and placement
- **D6057** Custom fabricated abutment – includes placement
- **D6058** Abutment supported porcelain/ceramic crown
- **D6059** Abutment supported porcelain fused to metal crown (high noble metal)
- **D6060** Abutment supported porcelain fused to metal crown (predominantly base metal)
- **D6061** Abutment supported porcelain fused to metal crown (noble metal)
- **D6062** Abutment supported cast metal crown (high noble metal)
- **D6063** Abutment supported cast metal crown (predominantly base metal)
- **D6064** Abutment supported cast metal crown (noble metal)
- **D6065** Implant supported porcelain/ceramic crown
- **D6066** Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- **D6067** Implant supported metal crown (titanium, titanium alloy, high noble metal)
- **D6068** Abutment supported retainer for porcelain/ceramic FPD
- **D6069** Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- **D6070** Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- **D6071** Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- **D6072** Abutment supported retainer for cast metal FPD (high noble metal)
- **D6073** Abutment supported retainer for cast metal FPD (predominantly base metal)
- **D6074** Abutment supported retainer for cast metal FPD (noble metal)
- **D6075** Implant supported retainer for ceramic FPD
- **D6076** Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
- **D6077** Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
- **D6080** Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
- **D6090** Repair implant supported prosthesis, by report
- **D6091** Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
- **D6094** Abutment supported crown (titanium)
- **D6095** Repair implant abutment, by report
- **D6100** Implant removal, by report
- **D6110** Implant/abutment supported removable denture for edentulous arch – maxillary
- **D6111** Implant/abutment supported removable denture for edentulous arch – mandibular
- **D6112** Implant/abutment supported removable denture for partially edentulous arch – maxillary
- **D6113** Implant/abutment supported removable denture for partially edentulous arch – mandibular
- **D6114** Implant/abutment supported fixed denture for edentulous arch – maxillary
- **D6115** Implant/abutment supported fixed denture for edentulous arch – mandibular
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6116</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - maxillary</td>
</tr>
<tr>
<td>D6117</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch - mandibular</td>
</tr>
</tbody>
</table>

**Prosthodontic Services - Removable**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture - cast metal framework with resin denture bases (including conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases (including conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5281</td>
<td>Removable unilateral partial denture - one-piece cast metal (including clasps and teeth)</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
</tr>
<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
</tr>
</tbody>
</table>

**Prosthodontic Services - Fixed**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6194</td>
<td>Abutment supported retainer crown for FPD (titanium)</td>
</tr>
<tr>
<td>D6210</td>
<td>Pontic – cast high noble metal</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic – cast predominantly base metal</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic – cast noble metal</td>
</tr>
<tr>
<td>D6214</td>
<td>Pontic – titanium</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic – porcelain fused to predominantly based metal</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic – porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6245</td>
<td>Pontic – porcelain/ceramic</td>
</tr>
<tr>
<td>D6545</td>
<td>Retainer – cast metal for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6548</td>
<td>Retainer – porcelain/ceramic for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6549</td>
<td>Resin retainer – for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6600</td>
<td>Retainer inlay – porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6601</td>
<td>Retainer inlay – porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer inlay – cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer inlay – cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer onlay – porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6609</td>
<td>Retainer onlay – porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer onlay – cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer onlay – cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6740</td>
<td>Retainer crown – porcelain/ceramic</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer crown – porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6752</td>
<td>Retainer crown – porcelain fused to predominantly base metal</td>
</tr>
</tbody>
</table>
noble metal

D6780  Retainer crown – ¾ cast high noble metal
D6781  Retainer crown – ¾ cast predominantly base metal
D6782  Retainer crown – ¾ cast noble metal
D6783  Retainer crown – ¾ 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
D9940  Occlusal guard, by report
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
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

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
Policy Limitations for Diagnostic Services (Class I Services)

1. Two oral evaluations (D0120, D0150 and D0180) are covered in a 12-consecutive-month period. 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 12-consecutive-month period.

3. Only one limited oral evaluation, problem-focused (D0140) will be allowed per patient per dentist in a 12-consecutive-month period. A limited oral evaluation will be considered integral when provided on the same date of service by the same dentist as any other oral evaluation.

4. Re-evaluations are considered integral to the originally performed procedures.

5. A full-mouth series (complete series) of radiographic images includes bitewings. Any additional radiographic image taken with a complete radiographic image series is considered integral to the complete series.

6. A panoramic radiographic image taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.

7. If the total fee for individually listed radiographic images equals or exceeds the fee for a complete series, these radiographic images are paid as a complete series and are subject to the same benefit limitations.

8. Payment for more than one of any category of full-mouth radiographic images within a 48-month period is the patient’s responsibility. If a full-mouth series (complete series) is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional radiographic images.

9. Payment for panoramic radiographic images is limited to one within a 48-month period.

10. Payment for periapical radiographic images (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.

11. Payment for a bitewing survey, whether single, two, three, four or vertical radiographic image(s), including those taken as part of a complete series, is limited to one within a 12-month period.

12. Radiographic images of non-diagnostic quality are not payable.

13. Test reports must describe the pathological condition, type of study and rationale.

Policy Limitations for Preventive Services (Class I Services)

1. Two routine prophylaxes are covered in a 12-consecutive-month period to the day.

2. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance procedures.

3. Routine prophylaxes are considered integral when performed in conjunction with or as a finishing procedure to periodontal scaling and root planning, periodontal maintenance, gingivectomies or gingivoplasties, gingival flap procedures, mucogingival surgery, or osseous surgery.

4. Routine prophylaxis includes associated scaling and polishing procedures. There are no provisions for any additional allowance based on degree of difficulty.

5. Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and paid as such. Participating dentists may not bill the patient for any difference in fees.

6. Two topical fluoride applications are covered in a 12-consecutive-month period for children to age 19.

7. Space maintainers are only covered for dependent children under the age of 19.

8. Sealants are covered on permanent molars for 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.

9. Sealants for teeth other than permanent molars are not covered.

10. Sealants provided on the same date of service and on the same tooth as a restorations of the occlusal surface are considered integral procedures.

11. 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.
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 24 months of the same surgical periodontal procedure in the same area of the mouth are not covered.

2. Gingivectomy or gingivoplasty performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered integral to the restoration.

3. Surgical periodontal procedures or scaling and root planning in the same area of the mouth within 24 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 24 months of osseous surgery in the same area of the mouth.

8. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service by the same dentist and in the same area of the mouth will be processed as crown lengthening.

9. Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or interbony defects. It is not covered when provided to obtain root coverage or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g., apicoectomy or hemisection.

10. One crown lengthening per tooth per lifetime is covered.

11. Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing or periodontal surgical procedures in the same area of the mouth are not covered.

12. A routine prophylaxis is considered integral when performed in conjunction with, or as a finishing procedure to, periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty, gingival flap procedure or osseous surgery.

13. Up to four 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.
Policy Limitations for Oral Surgery Services (Class II Services)

1. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
2. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.
3. Charges for related services such as necessary wires and splints, adjustments, and follow-up visits are considered integral to the fee for reimplantation and/or stabilization.
4. Routine postoperative care such as suture removal is considered integral to the fee for the surgery.
5. The removal of impacted teeth is paid based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, payment will be based on the allowance for the lesser level.
6. Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless specific documentation is provided that substantiates the need for removal.
7. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.
8. The fee for frenulectomy is included when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist.

Policy Limitations for Adjunctive General Services (Class II Services)

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered 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.

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 covered only if the existing denture or implant was inserted at least five years prior to the adjustment and the denture or implant is not and cannot be made serviceable.
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.

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 by report for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one per 12-consecutive-month period. Dependent children under the age of 13 are not eligible for an occlusal guard.

6. Athletic mouth guards are limited to one per 12-consecutive-month period.

7. Internal bleaching of discolored teeth (D9974) is covered by report for endodontically treated anterior teeth. A postoperative x-rays is required for consideration if the endodontic therapy has not been submitted to the Contractor for payment.

8. Internal bleaching of discolored teeth (D9974) is eligible once per tooth per three-year period.

Policy Limitations for Orthodontics (Class IV Services)
1. Initial payment for orthodontic services will not be made until a banding date has been submitted.

2. All retention and case-finishing procedures are integral to the total case fee.

3. Observations and adjustments are integral to the payment for retention appliances. Repair of damaged orthodontic appliances is not covered.

4. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is integral to the orthodontic appliance. However, recementation by a different dentist will be considered for payment as palliative treatment.

5. The replacement of a lost or missing appliance is not a covered benefit.

6. Myofunctional therapy is integral to orthodontic treatment and not payable as a separate benefit.

7. Orthodontic treatment (alternative billing to contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.

8. Periodic orthodontic treatment visits are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate services. Delta Dental uses this code when making periodic payments as part of the complete treatment plan payment.

9. It is the dentist’s and the patient’s responsibility to promptly notify Delta Dental if orthodontic treatment is discontinued or completed sooner than anticipated.

10. Post-operative orthodontic records including radiographs, models and records taken during treatment are included in the fee for the orthodontic treatment.

11. When a patient transfers to a different orthodontic dentist, payment and any additional records, etc. will be subject to review and recalculation of benefits.

12. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

**Exclusions (Non-covered Services)**

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

1. Any dental service or treatment not specifically listed as a covered service.

2. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the Contractor will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.

3. Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse. This includes spouse, siblings, parents, children, grandparents and the spouse’s siblings and parents.

4. Those submitted by a dentist which are for the same services performed on the same date for the same patient by another dentist.

5. Those which are experimental or investigative (deemed unproven).

6. Those which are for any illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the patient claims the benefits or compensation.

7. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.

8. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.

9. Those for which the patient would have no obligation to pay in the absence of this or any similar coverage.

10. Those 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).

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.


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.


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.