Veterans Affairs Dental Insurance Program

Complete Dentist Handbook for Treating Patients Enrolled in Delta Dental’s Veterans Affairs Dental Insurance Program

deltadentalvadip.org
Delta Dental’s Veterans Affairs Dental Insurance Program (VADIP)

For the first time in history, the U.S. government has authorized a national voluntary dental insurance program for eligible Veterans Affairs (VA) beneficiaries. The VADIP is offered by Delta Dental through the Department of Veterans Affairs and is administered by the Federal Government Programs division, located in Sacramento, California.

Delta Dental’s Veterans Affairs Dental Insurance Program (VADIP) offers cost-effective dental coverage with three plan options designed to meet the various needs of VA beneficiaries.

Delta Dental began enrolling eligible VA beneficiaries in its new VADIP program as of November 15, 2013, with coverage effective January 1, 2014.

Eligibility

Eligible VADIP beneficiaries include:

- Any Veteran enrolled in VA healthcare
- Any individual enrolled in VA’s Civilian Health and Medical Program (CHAMPVA).
  
  Dependent who do not qualify as a CHAMPVA beneficiary are not eligible.

Enrollment in VADIP is voluntary. Each new VADIP subscriber must commit to remain enrolled for an initial 12-month period. There are limited provisions for voluntary disenrollment during the initial 12-month enrollment period.

Enrollees who fail to complete their initial enrollment commitment are subject to a 12-month lockout period before they are eligible to re-enroll in VADIP. Enrollees who disenroll from VADIP after completing the initial 12-month enrollment obligations may re-enroll at any time but will be subject to the same initial 12-month enrollment commitment and any applicable waiting periods as a new VADIP enrollee.

VADIP Service Area

Dental coverage under Delta Dental’s VADIP is offered nationwide to enrollees, with benefits based on primary residence. Enrollees in VADIP are eligible for covered benefits within the service area that includes 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. There is no overseas coverage under Delta Dental’s VADIP.

Participating VADIP Network Dentists

The Delta Dental PPO dentist network (DPO in Texas) with over 200,000 locations nationwide is “in network” for the VADIP. When a VADIP enrollee seeks care from a Delta Dental PPO network dentist, a higher percentage of coverage is applied than if the enrollee saw an out-of-network dentist. The PPO fees are used for processing claims for both the allowed and approved amounts.
Out-of-Network Dentists

Dentists who do not belong to the Delta Dental PPO network (DPO in Texas) are considered out-of-network dentists for VADIP. Out-of-network dentists include other Delta Dental dentists (such as Delta Dental Premier-dentists) as well as non-Delta Dental dentists.

Claims Submission and Payment

Claims Submission

Delta Dental’s VADIP does not require special claim forms. Claim forms are available on the VADIP website at deltadentalvadip.org. The claim form will need to be printed and then completed; submit the claim directly to Delta Dental, as follows:

Delta Dental of California
Federal Government Programs
PO Box 537009
Sacramento, CA 95853-7009

For Delta Dental to process your claim quickly, it is important the claim form is filled out completely and correctly. The following information is required on the claim form:

- The patient’s name and birth date
- The subscriber’s name, mailing address and birth date
- The subscriber’s identification number
- The treating dentist’s name and license number
- The treating dentist’s treatment office address, city, state and zip code
- The date the service(s) was completed
- A description of the service(s) provided
- The appropriate CDT procedure code that corresponds to the service(s) provided
- The treating dentist’s customary fee for the service(s)
- The tooth number/letter and surface/arch, as appropriate

Claims for covered services should be completed and submitted to Delta Dental as soon as possible after the service is provided. Claims must be received by Delta Dental within 12 months of the last date of service in order to be processed. Claims received on or after the first day of the month following 12 months of the last date of service will be denied by Delta Dental.

Delta Dental network dentists cannot charge a VADIP patient for Delta Dental’s portion of the services that are denied because the claim was submitted late.

Coordination of Benefits (COB)

If the enrollee has other dental coverage in addition to VADIP coordination of benefits (COB) guidelines should be applied when processing a claim. For example, this may occur if the subscriber has another job or if the subscriber’s spouse has a job and has dental benefits through that job.
It is the patient’s responsibility to let the dentist know when there is other coverage. Most dental carriers coordinate benefits when secondary coverage is noted on the claim, allowing patients to make use of their coverage under both programs. Payment is based on the type of benefit programs involved (e.g., fee for-service, indemnity, preferred provider organization (PPO), etc.) and the guidelines for coordination between these programs as established by the National Association of Insurance Commissioners (NAIC).

When submitting a claim form, please ensure the “Other Coverage” portion of the claim is completed to ensure that all benefits are appropriately coordinated. In cases where there is other dental coverage, the following COB rules determine coverage and payment as primary and/or secondary:

- The claim should be filed first with the plan that pays first. Information about the first plan’s payment is used by the other plan to determine its payment. If Delta Dental pays first, the other plan will determine how much it will pay after the Delta Dental payment has been made. If the other plan pays first, Delta Dental will determine how much it will pay after the other plan has paid.
- Delta Dental will generally make the first payment if the other coverage is not principally a dental program.
- 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.
- 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.

If a child is covered under two different plans, the first coverage to pay usually depends on which parent’s birthday is earlier in the year. For example, if the mother was born on May 1 and the father was born on May 5, all the children will be covered by their mother’s plan first. This is because the mother’s birthday is earlier in the year than the father’s. The parents’ year of birth does not matter—only the month and day are considered. This “birthday rule” is defined by the NAIC.

In custody cases, the determination of first coverage and second coverage can be difficult. In most cases, if one parent has been awarded custody, the child is covered by that parent’s coverage first and by the noncustodial parent’s coverage second. If the parent with custody remarries, his or her coverage usually pays first and the stepparent’s coverage pays second. If the custodial parent does not have other coverage, but the child’s stepparent does, then the stepparent’s coverage may pay first and the non-custodial parent’s coverage pays second. Sometimes it is not possible to determine which coverage should pay first even after checking these rules. In this case, whichever dental plan has covered the person the longest usually pays first. In special circumstances, a court may decide that some other rule should apply.
Summary of Benefits
Veterans Affairs Dental Insurance Program (VADIP)

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Standard In Network</th>
<th>Standard Out of Network</th>
<th>Enhanced In Network</th>
<th>Enhanced Out of Network</th>
<th>Comprehensive In Network</th>
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</table>

1. Under the Enhanced plan both in-network and out-of-network the deductible is waived for diagnostic and preventive services.
2. Under the Comprehensive plan for out-of-network the deductible is waived for diagnostic and preventive services; under the Comprehensive plan for all in-network services there is no deductible.
3. Under the Comprehensive plan there is a waiting period of twelve (12) months for major restorative, oral surgery and prosthodontic services.
4. Under the standard and enhanced plans, routine extractions are the only oral surgery services covered; under the Comprehensive plan, routine extractions are the only oral surgery services covered in the first 12-months.
5. Orthodontics is not a benefit (NAB) under any of the plans.
Standard Plan: Covered Services

Diagnostic Services

D0120 Periodic oral evaluation
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 Extraoral—first film
D0260 Extraoral—each additional film
D0270 Bitewing—single radiographic image
D0272 Bitewings—two radiographic images
D0273 Bitewings—three radiographic images
D0274 Bitewings—four radiographic images
D0277 Vertical bitewings—seven to eight radiographic images
D0330 Panoramic radiographic image
D0425 Caries susceptibility tests

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

D1110 Prophylaxis—adult
D1120 Prophylaxis—child through age 13
D1201 Topical application of fluoride (including prophylaxis)—child
D1206 Topical fluoride varnish; therapeutic application for moderate- to high-risk caries patients
D1208 Topical application of fluoride—child to age 19; one per six-month period
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  Recementation of space maintainer

Policy Limitations for Preventive Services
1. Two routine prophylaxes are covered in a 12-consecutive-month period.
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.

Basic Restorative Services

D2140  Amalgam—one surface, primary or permanent
D2150  Amalgam—two surfaces, primary or permanent
D2160  Amalgam—three surfaces, primary or permanent
D2161  Amalgam—four or more surfaces, primary or permanent
D2330  Resin-based composite—one surface, anterior
D2331  Resin-based composite—two surfaces, anterior
D2332  Resin-based composite—three surfaces, anterior
D2335  Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2391  Resin-based composite—one surface, posterior
D2392  Resin-based composite—two surfaces, posterior
D2393  Resin-based composite—three surfaces, posterior
D2394  Resin-based composite—four or more surfaces, posterior
D2910  Recement inlay, onlay, or partial coverage restoration
D2920  Recement crown
D2930  Prefabricated stainless steel crown—primary tooth
D2931  Prefabricated stainless steel crown—permanent tooth
D2951  Pin retention—per tooth, in addition to restoration
D3427  Periradicular surgery without apicoectomy

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. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.

17. Those resulting from the patient’s failure to comply with professionally prescribed treatment.

18. Telephone consultations.

19. Any charges for failure to keep a scheduled appointment.

20. Duplicate and temporary devices, appliances, and services.

21. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).

22. Plaque control programs, oral hygiene instruction, and dietary instructions.

23. 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. 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.

26. 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.

27. Services or treatment provided as a result of intentionally self-inflicted injury or illness.

28. 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.

29. Office infection control charges.

30. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).

31. Adjunctive dental services as defined by applicable federal regulations.

32. 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.

33. Nitrous oxide.

34. Oral sedation.

35. State or territorial taxes on dental services performed.
Enhanced Plan: Covered Services

Diagnostic Services

D0120  Periodic oral evaluation  
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  Extraoral—first film  
D0260  Extraoral—each additional film  
D0270  Bitewing—single radiographic image  
D0272  Bitewings—two radiographic images  
D0273  Bitewings—three radiographic images  
D0274  Bitewings—four radiographic images  
D0277  Vertical bitewings—seven to eight radiographic images  
D0330  Panoramic radiographic image  
D0425  Caries susceptibility tests

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

D1110  Prophylaxis—adult  
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D1206  Topical fluoride varnish; therapeutic application for moderate- to high-risk caries patients  
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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  Recementation of space maintainer

Policy Limitations for Preventive Services

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

Basic Restorative Services

D2140  Amalgam—one surface, primary or permanent
D2150  Amalgam—two surfaces, primary or permanent
D2160  Amalgam—three surfaces, primary or permanent
D216  Amalgam—four or more surfaces, primary or permanent
D2330  Resin-based composite—one surface, anterior
D2331  Resin-based composite—two surfaces, anterior
D2332  Resin-based composite—three surfaces, anterior
D2335  Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2391  Resin-based composite—one surface, posterior
D2392  Resin-based composite—two surfaces, posterior
D2393  Resin-based composite—three surfaces, posterior
D2394  Resin-based composite—four or more surfaces, posterior
D2910  Recement inlay, onlay, or partial coverage restoration
D2920  Recement crown
D2930  Prefabricated stainless steel crown—primary tooth
D2931  Prefabricated stainless steel crown—permanent tooth
D2951  Pin retention—per tooth, in addition to restoration

Policy Limitations for Basic Restorative Services

1. Diagnostic casts (study models) taken in conjunction with restorative procedures are considered integral.
2. Sedative restorations are not a covered benefit.
3. Pin retention is covered only when reported in conjunction with an eligible restoration.
4. An amalgam or resin restoration reported with a pin (D2951), in addition to a crown, is considered to be a pin buildup (D2950).
5. Preventive resin restorations or other restorations that do not extend into the dentin are considered sealants for purposes of determining benefits.
6. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are considered integral procedures, and a separate fee is not chargeable to the member by a participating dentist. However, payment may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.
7. Restorations are not covered when performed after the placement of any type of crown on the same tooth and by the same dentist.
8. The payment for restorations includes all related services to include, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
9. Prefabricated stainless steel crowns (D2930, D2931) are covered only on primary teeth, permanent teeth through age 14, or when placed as a result of accidental injury. They are limited to one per patient, per tooth, per lifetime.
10. The charge for a crown should include all charges for work related to its placement to include, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.
11. Crowns are payable only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, payment will be made for that service. This payment can be applied toward the cost of the crown.
12. Recementation of prefabricated and cast crowns, onlays, and inlays is eligible once per six month period. Recementation provided within 12 months of placement by the same dentist is considered integral.
13. Payment for a resin restoration will be made when a laboratory fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.

**Endodontic Services**

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

Policy Limitations for Endodontic Services
1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members up to age six and for primary molars and cuspids to age 11 and is limited to once per tooth per lifetime. Payment for the pulpal therapy will be offset by the allowance for a pulpotomy provided within 45 days preceding pulpal therapy on the same tooth by the same dentist.
4. Treatment of a root canal obstruction is considered an integral procedure.
5. Incomplete endodontic therapy is not a covered benefit when due to the patient discontinuing treatment.
6. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
7. Placement of a final restoration following endodontic therapy is a separate procedure, payable based on plan coverage.

Periodontic Services
D4210 Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4211 Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240 Gingival flap procedure, including root planning—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4241 Gingival flap procedure, including root planning—one to three contiguous teeth or tooth-bounded spaces per quadrant
D4249 Clinical crown lengthening—hard tissue
D4260 Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4261 Osseous surgery (including flap entry 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 Subepithelial connective tissue graft procedures, per tooth
D4275 Soft tissue allograft
D4276 Combined connective tissue and double pedicle graft, per tooth
D4277 Free soft-tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
D4278 Free soft-tissue graft procedure (including donor site surgery), each additional contiguous tooth 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
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, by report
D4910 Periodontal maintenance (following active therapy)
D7921 Collection and application of autologous blood concentrate product

Policy Limitations for Periodontal Services
1. Gingivectomy or gingivoplasty, gingival flap procedure, guided tissue regeneration, soft-tissue grafts, bone replacement grafts and osseous surgery provided within 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 and up to two routine prophylaxes may be paid within a 12-consecutive month period, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a 12-month period.
14. Periodontal maintenance is only covered when performed following active periodontal treatment.
15. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policy and limitations applicable to oral evaluations.
16. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure.
17. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.
18. Full mouth debridement to enable comprehensive evaluation and diagnosis (code D4355) is covered once per lifetime.

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. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
17. Those resulting from the patient’s failure to comply with professionally prescribed treatment.
18. Telephone consultations.
19. Any charges for failure to keep a scheduled appointment.
20. Duplicate and temporary devices, appliances, and services.
21. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
22. Plaque control programs, oral hygiene instruction, and dietary instructions.
23. 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. 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.
26. 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.
27. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
28. 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.
29. Office infection control charges.
30. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
31. Adjunctive dental services as defined by applicable federal regulations.
32. 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.
33. Nitrous oxide.
34. Oral sedation.
35. State or territorial taxes on dental services performed.
Comprehensive Plan: Covered Services

Diagnostic Services

D0120  Periodic oral evaluation
D0140  Limited oral evaluation—problem focused
D0145  Oral evaluation for patient under three years of age and counseling with primary caregiver
D0150  Comprehensive oral evaluation—new or established patient
D0160  Detailed and extensive oral evaluation, problem focused, by report
D0180  Comprehensive periodontal evaluation—new or established patient
D0210  Intraoral—complete series of radiographic images
D0220  Intraoral—periapical first radiographic image
D0230  Intraoral—periapical each additional radiographic image
D0240  Intraoral—occlusal radiographic image
D0250  Extraoral—first film
D0260  Extraoral—each additional film
D0270  Bitewing—single radiographic image
D0272  Bitewings—two radiographic images
D0273  Bitewings—three radiographic images
D0274  Bitewings—four radiographic images
D0277  Vertical bitewings—seven to eight radiographic images
D0330  Panoramic radiographic image
D0425  Caries susceptibility tests

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

D1110  Prophylaxis—adult
D1120  Prophylaxis—child through age 13
D1201  Topical application of fluoride (including prophylaxis) — child
Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

Topical application of fluoride—child to age 19; one per six-month period

Sealant—per tooth

Space maintainer—fixed—unilateral

Space maintainer—fixed—bilateral

Space maintainer—removable—unilateral

Space maintainer—removable—bilateral

Recementation of space maintainer

Policy Limitations for Preventive Services

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

Basic Restorative Services

Amalgam—one surface, primary or permanent

Amalgam—two surfaces, primary or permanent

Amalgam—three surfaces, primary or permanent

Amalgam—four or more surfaces, primary or permanent

Resin-based composite—one surface, anterior

Resin-based composite—two surfaces, anterior

Resin-based composite—three surfaces, anterior

Resin-based composite—four or more surfaces or involving incisal angle (anterior)

Resin-based composite—one surface, posterior

Resin-based composite—two surfaces, posterior

Resin-based composite—three surfaces, posterior

Resin-based composite—four or more surfaces, posterior

Recement inlay, onlay, or partial coverage restoration

Recement crown

Prefabricated stainless steel crown—primary tooth

Prefabricated stainless steel crown—permanent tooth

Pin retention—per tooth, in addition to restoration
Major Restorative Services

D2510 Inlay, metallic—one surface
D2520 Inlay, metallic—two surfaces
D2530 Inlay, metallic—three or more surfaces
D2542 Onlay, metallic—two surfaces
D2543 Onlay, metallic—three surfaces
D2544 Onlay, metallic—four or more surfaces
D2740 Crown—porcelain/ceramic 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—3/4 cast high noble metal
D2781 Crown—3/4 cast predominantly base metal
D2782 Crown—3/4 cast noble metal
D2783 Crown—3/4 porcelain/ceramic
D2790 Crown—full-cast high noble metal
D2791 Crown—full-cast predominantly base metal
D2792 Crown—full-cast high noble metal
D2794 Crown—titanium
D2954 Prefabricated post and core in addition to crown
D2980 Crown repair, by report
D2981 Inlay repair necessitated by restorative material failure
D2982 Onlay repair necessitated by restorative material failure
D2983 Veneer repair necessitated by restorative material failure
D2990 Resin infiltration of incipient smooth surface lesions—limited to permanent molars through age 15

Policy Limitations for Restorative Services

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

10. The charge for a crown or onlay should include all charges for work related to its placement to include, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.

11. Onlays, permanent single crown restorations, and posts and cores for members 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.).

12. Core buildups (D2950) can be considered for benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.

13. Cast posts and cores (D2952) are processed as an alternate benefit of a prefabricated post and core. The patient is responsible for the difference between the dentist’s charge for the cast post and core and the amount paid by for the prefabricated post and core.

14. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. Satisfactory evidence must show that the existing crown, onlay, buildup, or post and core is not and cannot be made serviceable. The five year service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.

15. Onlays, crowns, and posts and cores are payable only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, payment will be made for that service. This payment can be applied toward the cost of the onlay, crown, or post and core.

16. Crowns, inlays, onlays, buildups, or posts and cores, begun prior to the effective date of coverage or cemented after the cancellation date of coverage, are not eligible for payment.

17. Recementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts is eligible once per six-month period. Recementation provided within 12 months of placement by the same dentist is considered integral.

18. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown or implant and are considered integral to the buildup or implant.

19. Payment for a resin restoration will be made when a laboratory fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.

**Endodontic Services**

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

Policy Limitations for Endodontic Services
1. Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
2. A pulpotomy is covered when performed as a final endodontic procedure and is payable on primary teeth only. Pulpotomies performed on permanent teeth are considered integral to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.
3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth for members up to age six and for primary molars and cuspids to age 11 and is limited to once per tooth per lifetime. Payment for the pulpal therapy will be offset by the allowance for a pulpotomy provided within 45 days preceding pulpal therapy on the same tooth by the same dentist.
4. Treatment of a root canal obstruction is considered an integral procedure.
5. Incomplete endodontic therapy is not a covered benefit when due to the patient discontinuing treatment.
6. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.
7. Placement of a final restoration following endodontic therapy is eligible as a separate procedure, payable based on plan coverage.

Periodontic Services
D4210  Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4211  Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant
D4212  Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240  Gingival flap procedure, including root planning—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4241  Gingival flap procedure, including root planning—one to three contiguous teeth or tooth-bounded spaces per quadrant
D4249  Clinical crown lengthening—hard tissue
D4260  Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4261  Osseous surgery (including flap entry 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  Subepithelial connective-tissue graft procedures, per tooth
D4275  Soft tissue allograft
D4276  Combined connective tissue and double pedicle graft, per tooth
D4277  Free soft-tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
D4278  Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site
D4341  Periodontal scaling and root planning—four or more contiguous teeth or tooth-bounded spaces per quadrant
D4342  Periodontal scaling and root planning—one to three teeth, per quadrant
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, by report
D4910  Periodontal maintenance (following active therapy)
D7921  Collection and application of autologous blood concentrate product

Policy Limitations for Periodontal Services
1. Gingivectomy or gingivoplasty, gingival flap procedure, guided tissue regeneration, soft tissue grafts, bone replacement grafts and osseous surgery provided within 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 within 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, 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 and up to two routine prophylaxes may be paid within a 12-consecutive month period, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a 12-month period.

14. Periodontal maintenance is only covered when performed following active periodontal treatment.

15. An oral evaluation reported in addition to periodontal maintenance will be processed as a separate procedure subject to the policy and limitations applicable to oral evaluations.

16. Payment for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure. The lesser procedure is considered integral and its allowance is included in the allowance for the greater procedure.

17. Surgical revision procedure (D4268) is considered integral to all other periodontal procedures.

18. Full-mouth debridement to enable comprehensive evaluation and diagnosis (code D4355) is covered once per lifetime.

Prosthodontic Services

D5110 Complete denture—maxillary
D5120 Complete denture—mandibular
D5130 Immediate denture—maxillary
D5140 Immediate denture—mandibular
D5211 Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture—cast metal framework with resin denture bases (including conventional clasps, rests and teeth)
D5214 Mandibular partial denture—cast metal framework with resin denture bases (including conventional clasps, rests and teeth)
D5281 Removable unilateral partial denture—one-piece cast metal (including clasps and teeth)
D5410 Adjust complete denture—maxillary
D5411 Adjust complete denture—mandibular
D5421 Adjust partial denture—maxillary
D5422 Adjust partial denture—mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth—complete denture (each tooth)
D5610 Repair resin denture base (partial)
D5620 Repair cast framework (partial)
D5630 Repair or replace broken clasp
D5640 Replace broken teeth—per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750  Reline complete maxillary denture (laboratory)
D5751  Reline complete mandibular denture (laboratory)
D5760  Reline mandibular 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
D6053  Implant/abutment supported removable denture for completely edentulous arch
D6054  Implant/abutment supported removable denture for partially edentulous arch
D6055  Dental implant supported connecting bar
D6056  Prefabricated abutment—includes placement
D6057  Custom 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)
D6078  Implant/abutment supported fixed denture for completely edentulous arch
D6079  Implant/abutment supported fixed denture for partially edentulous arch
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 crowns, 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<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 base metal</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6245</td>
<td>Pontic—porcelain/ceramic substrate</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>D6600</td>
<td>Inlay—porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6601</td>
<td>Inlay—porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6604</td>
<td>Inlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6605</td>
<td>Inlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6608</td>
<td>Onlay—porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6609</td>
<td>Onlay—porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6612</td>
<td>Onlay—cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6613</td>
<td>Onlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6740</td>
<td>Crown—porcelain/ceramic</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown—porcelain fused to noble metal</td>
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<tr>
<td>D6780</td>
<td>Crown—3/4 cast high noble metal</td>
</tr>
<tr>
<td>D6781</td>
<td>Crown—3/4 cast predominantly base metal</td>
</tr>
<tr>
<td>D6782</td>
<td>Crown—3/4 cast noble metal</td>
</tr>
<tr>
<td>D6783</td>
<td>Crown—3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D6790</td>
<td>Crown—full cast high noble metal</td>
</tr>
<tr>
<td>D6791</td>
<td>Crown—full cast predominantly base metal</td>
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<tr>
<td>D6792</td>
<td>Crown—full cast noble metal</td>
</tr>
<tr>
<td>D6794</td>
<td>Crown—titanium</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>
</tbody>
</table>

**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 (D5110 through D5214) and fixed prostheses (D6210 through D6792) 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 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth—soft tissue
D7230 Removal of impacted tooth—partially bony
D7240 Removal of impacted tooth—completely bony
D7241 Removal of impacted tooth—completely bony, with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy—intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7311 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—introral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingival
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

D9110  Palliative (emergency) treatment of dental pain—minor procedure
D9220  Deep sedation/general anesthesia—first 30 minutes
D9221  Deep sedation/general anesthesia—each additional 15 minutes
D9241  Intravenous sedation/analgesia—first 30 minutes
D9242  Intravenous sedation/analgesia—each additional 15 minutes
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

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. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
17. Those resulting from the patient’s failure to comply with professionally prescribed treatment.
18. Telephone consultations.
19. Any charges for failure to keep a scheduled appointment.
20. Duplicate and temporary devices, appliances, and services.
21. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
22. Plaque control programs, oral hygiene instruction, and dietary instructions.
23. 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. 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.
26. 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.
27. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
28. 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.
29. Office infection control charges.
30. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
31. Adjunctive dental services as defined by applicable federal regulations.
32. 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.
33. Nitrous oxide.
34. Oral sedation.
35. State or territorial taxes on dental services performed.

VADIP is administered and underwritten by Delta Dental of California through its subsidiary, Delta Dental Insurance Company.