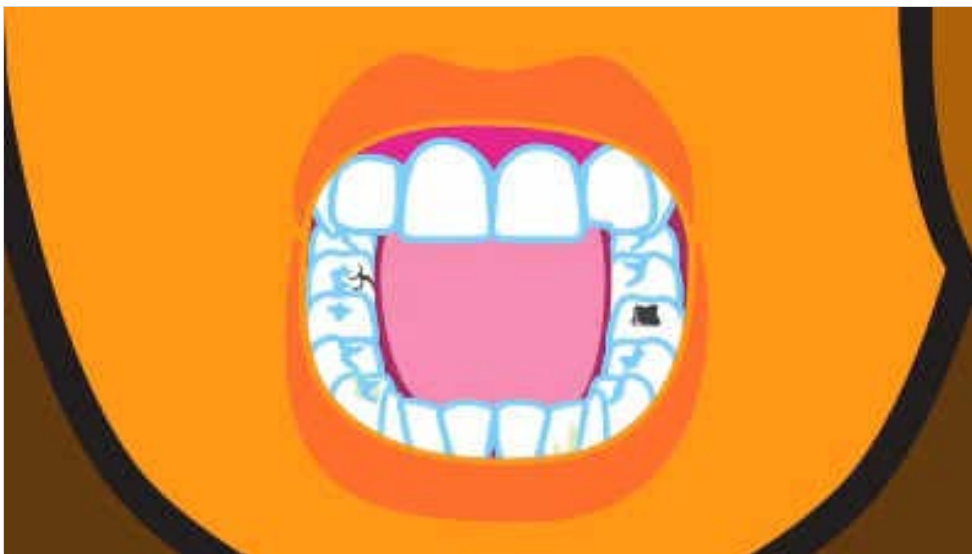


DeltaCare[®] USA (DHMO)

Under the DeltaCare[®] USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the copayments for the covered services on the following pages.



Click to play Dental Video:



>> Benefit Eligibility Note:

- **All M-DCPS groups are eligible to enroll in the DeltaCare USA (DHMO) offered by the School Board.**
- **Current COBRA participants may only continue to enroll in DeltaCare USA (DHMO) if you were previously enrolled in vision.**
- **See eligibility section for more details.**



Healthy Tip:

Preschedule your next dental appointment at the end of your dental visit to maintain routine treatment for yourself and your family members.

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.



DeltaCare[®] USA (DHMO)

DeltaCare USA Plans - DHMO Dental Plans

Dental services that are not performed by your selected in-network participating (contracted) dentist, or are not covered under provisions for emergency care below, must be preauthorized by us to be covered by your DeltaCare USA program.

The program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits.

Your participating in-network (contracted) dentist will coordinate your specialty care needs for oral surgery, endodontics or periodontics with an approved in-network (contracted) specialist. There is no additional charge to you for receiving care from a specialist. If there is no participating specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment.

How to use your DeltaCare USA Plan:

A list of participating plan providers in Miami-Dade, Broward, Monroe and Palm Beach Counties can be viewed online at www.deltadentalins.com/mdcps. You may also call Customer Service at 1.800.693.2589. Multilingual representatives are available from 8 a.m. to 9 p.m. Eastern Time, Monday through Friday.

How can I make an appointment with my DeltaCare USA dentist?

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, inform the office that you are a member of the DeltaCare USA dental plan. It will not be necessary to use any claim forms. If you need to cancel your appointment for any reason, please let your provider know twenty-four (24) hours in advance of your scheduled appointment. The Benefits Schedule allows the provider to charge a fee (up to a maximum of \$25) for any broken or cancelled appointment without twenty-four (24) hours' notice.

How long does it take to get an appointment with a DeltaCare USA dentist?

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren under your or your spouse's legal guardianship until the end of the calendar year in which the child reaches age 26
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

NOTE: Children may be covered under this plan until the end of the calendar year in which the child reaches age 26, provided he/she is unmarried and resides in your home and depends upon you for support, or is registered as a full-time or part-time student. Children with a mental or physical handicap are also eligible for coverage beyond the age of 26.

Can I change my contract dentist?

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website, www.deltadentalins.com/mdcps. If you contact us by the 21st of the month, the change will become effective the first of the following month.

What if I need the services of a Specialist?

Your participating dentist will coordinate your specialty care needs for oral surgery, endodontics or periodontics with an approved contract specialist. There is no additional charge to you for receiving care from a specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment.

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DeltaCare[®] USA (DHMO)

What can I do if I have questions about the treatment plan prescribed by my General Dentist?

Call DeltaCare Customer Service at 1.800.693.2589 Monday through Friday 8 a.m. - 9 p.m. ET.

What if I'm currently seeing a dentist under one plan and I change plans to the DeltaCare USA Plan, but would like to maintain the same dentist?

As long as the dentist is part of the DeltaCare USA network and is accepting patients, you may select the facility as your primary dentist. If the facility is not open to new membership, you will have to select another participating provider.

How can I receive emergency care within the service area?

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist). Your program pays up to \$100 for out-of-area emergency dental expenses per emergency for each enrollee.

How can I receive emergency care for out-of-area?

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist). Your program pays up to \$100 for out-of-area emergency dental expenses per emergency for each enrollee.

What if I have questions about my DeltaCare USA program?

Call Customer Service at 1.800.693.2589. We have multilingual representatives available from 8 a.m. to 9 p.m. Eastern time, Monday through Friday. Our Customer Service representatives can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

Are pre-existing dental conditions and work in progress covered?

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

How to use dental benefits:

A list containing the Select Panel Providers in Miami-Dade, Broward, Monroe and Palm Beach Counties can be viewed online at www.deltadentalins.com/mdcps. You may call the DeltaCare Customer Services Department at 1.800.693.2589 to verify your dentist's continued participation in your selected plan.



DeltaCare® USA (DHMO)

Standard Plan

SCHEDULE A

Description of Benefits and Copayments Standard Plan

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

All non-listed services are available with your selected Contract Dentist or Contract Specialist at 75% of their filed fees.

| Code | Description | Enrollee Pays | | |
|--------------------|---|---------------|----------------------|--|
| D0100-D0999 | | | I. DIAGNOSTIC | |
| D0120 | Periodic oral evaluation - established patient | \$0.00 | D0415 | Collection of microorganisms for culture and sensitivity \$0.00 |
| D0140 | Limited oral evaluation - problem focused | \$0.00 | D0425 | Caries susceptibility tests \$0.00 |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | \$0.00 | D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures \$50.00 |
| D0150 | Comprehensive oral evaluation - new or established patient | \$0.00 | D0460 | Pulp vitality tests \$0.00 |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | \$0.00 | D0470 | Diagnostic casts \$0.00 |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | \$0.00 | D0472 | Accession of tissue, gross examination, preparation and transmission of written report. \$0.00 |
| D0171 | Re-evaluation - post-operative office visit | \$0.00 | D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report. \$0.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | \$20.00 | D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report. \$0.00 |
| D0190 | Screening of a patient | \$0.00 | D0486 | Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report \$0.00 |
| D0191 | Assessment of a patient | \$0.00 | D0601 | Caries risk assessment and documentation, with a finding of low risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0210 | intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i> | \$0.00 | D0602 | Caries risk assessment and documentation, with a finding of moderate risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0220 | Intraoral - periapical first radiographic image | \$0.00 | D0603 | Caries risk assessment and documentation, with a finding of high risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0230 | Intraoral - periapical, each additional radiographic image | \$0.00 | D0999 | Unspecified diagnostic procedure, by report - <i>includes office visit, per visit including all fees for sterilization and/or infection control (in addition to other services)</i> \$5.00 |
| D0240 | Intraoral - occlusal radiographic image | \$0.00 | | |
| D0250 | Extraoral - first radiographic image | \$0.00 | | |
| D0260 | Extraoral - each additional radiographic image | \$0.00 | | |
| D0270 | Bitewing radiograph - single radiographic image | \$0.00 | | |
| D0272 | Bitewings radiographs - two radiographic images | \$0.00 | | |
| D0273 | Bitewings - radiographs - three radiographic images | \$0.00 | | |
| D0274 | Bitewings radiographs - four radiographic images - <i>limited to 1 series every 6 months</i> | \$0.00 | | |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | \$0.00 | | |
| D0330 | Panoramic radiographic image | \$0.00 | | |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally | \$0.00 | | |
| D0351 | 3D photographic image | \$0.00 | | |

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DeltaCare® USA (DHMO)

Standard Plan

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| D1000-D1999 | II. PREVENTIVE | D2392 Resin-based composite - two surfaces, posterior | \$85.00 |
| D1110 Prophylaxis cleaning - adult - 2 per year | \$0.00 | D2393 Resin-based composite - three surfaces, posterior | \$95.00 |
| <i>D1110 Additional prophylaxis cleaning - adult; 2 within year</i> | \$35.00 | D2394 Resin-based composite - four or more surfaces, posterior | \$120.00 |
| D1120 Prophylaxis cleaning - child - 2 per year | \$0.00 | D2510 Inlay - metallic - one surface | \$155.00 |
| <i>D1120 Additional prophylaxis cleaning - child; 2 within year</i> | \$35.00 | D2520 Inlay - metallic - two surfaces | \$165.00 |
| D1206 Topical application of fluoride varnish - 2 per year; 2 D1206 or D1208 per year | \$0.00 | D2530 Inlay - metallic - three or more surfaces | \$190.00 |
| D1208 Topical application of fluoride - excluding varnish - 2 per year; 2 D1206 or D1208 per year | \$0.00 | D2542 Onlay - metallic - two surfaces | \$370.00 |
| D1310 Nutritional counseling for control of dental disease. | \$0.00 | D2543 Onlay - metallic - three surfaces | \$370.00 |
| D1320 Tobacco counseling for the control and prevention of oral disease | \$0.00 | D2544 Onlay - metallic - four or more surfaces | \$370.00 |
| D1330 Oral hygiene instructions | \$0.00 | D2610 Inlay - porcelain/ceramic - one surface | \$370.00 |
| D1351 Sealant - per tooth - limited to permanent molars through age 15 | \$0.00 | D2620 Inlay - porcelain/ceramic - two surfaces | \$370.00 |
| D1352 Preventive resin restoration in a moderate to high carries risk patient - permanent tooth | \$0.00 | D2630 Inlay - porcelain/ceramic - three or more surfaces | \$370.00 |
| D1353 Sealant repair - per tooth - limited to permanent molars through age 15 | \$0.00 | D2642 Onlay - porcelain/ceramic - two surfaces | \$370.00 |
| D1510 Space maintainer - fixed - unilateral | \$65.00 | D2643 Onlay - porcelain/ceramic - three surfaces | \$370.00 |
| D1515 Space maintainer - fixed - bilateral | \$65.00 | D2644 Onlay - porcelain/ceramic - four or more surfaces | \$370.00 |
| D1520 Space maintainer - removable - unilateral | \$105.00 | D2650 Inlay - resin-based composite - one surface | \$370.00 |
| D1525 Space maintainer - removable - bilateral | \$105.00 | D2651 Inlay - resin-based composite - two surfaces | \$370.00 |
| D1550 Re-cement or re-bond space maintainer | \$15.00 | D2652 Inlay - resin-based composite - three or more surfaces | \$370.00 |
| D1555 Removal of fixed space maintainer | \$15.00 | D2662 Onlay - resin-based composite - two surfaces | \$370.00 |
| D2000-D2999 | III. RESTORATIVE | D2663 Onlay - resin-based composite - three surfaces | \$370.00 |
| - Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures. | | D2664 Onlay - resin-based composite - four or more surfaces | \$370.00 |
| - An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no copayment per crown unit in addition to regular copayments for porcelain on molars. | | D2710 Crown - resin (indirect) | \$370.00 |
| - When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$125.00 per crown, beyond the 6th unit. | | D2712 Crown - ¾ resin-based composite (indirect) | \$370.00 |
| - Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old. | | D2720 Crown - resin with high noble metal | \$370.00 |
| D2140 Amalgam - one surface, primary or permanent | \$20.00 | D2721 Crown - resin with predominantly base metal | \$370.00 |
| D2150 Amalgam - two surfaces, primary or permanent | \$25.00 | D2722 Crown - resin with noble metal | \$370.00 |
| D2160 Amalgam - three surfaces, primary or permanent | \$30.00 | D2740 Crown - porcelain/ceramic substrate | \$370.00 |
| D2161 Amalgam - four or more surfaces, primary or permanent | \$35.00 | D2750 Crown - porcelain fused to high noble metal | \$370.00 |
| D2330 Resin-based composite - one surface, anterior | \$35.00 | D2751 Crown - porcelain fused to predominantly base metal | \$370.00 |
| D2331 Resin-based composite - two surfaces, anterior | \$40.00 | D2752 Crown - porcelain fused to noble metal | \$370.00 |
| D2332 Resin-based composite - three surfaces, anterior | \$50.00 | D2780 Crown - ¾ cast high noble metal | \$370.00 |
| D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior) | \$55.00 | D2781 Crown - ¾ cast predominantly base metal | \$370.00 |
| D2390 Resin-based composite crown, anterior | \$65.00 | D2782 Crown - ¾ cast noble metal | \$370.00 |
| D2391 Resin-based composite - one surface, posterior | \$75.00 | D2783 Crown - ¾ porcelain/ceramic | \$370.00 |
| | | D2790 Crown - full cast high noble metal | \$370.00 |
| | | D2791 Crown - full cast predominantly base metal | \$370.00 |
| | | D2792 Crown - full cast noble metal | \$370.00 |
| | | D2794 Crown - titanium | \$370.00 |
| | | D2799 Provisional crown | \$0.00 |
| | | D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | \$15.00 |
| | | D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core | \$0.00 |
| | | D2920 Re-cement or re-bond crown | \$15.00 |
| | | D2921 Reattachment of tooth fragment, incisal edge or cusp (anterior) | \$55.00 |

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| D2929 Prefabricated porcelain/ceramic crown – (anterior) primary tooth | \$45.00 | D3310 Root canal - endodontic therapy, anterior tooth (excluding final restoration) | \$200.00 |
| D2930 Prefabricated stainless steel crown - primary tooth | \$25.00 | D3320 Root canal - endodontic therapy, bicuspid tooth (excluding final restoration) | \$210.00 |
| D2931 Prefabricated stainless steel crown - permanent tooth | \$25.00 | D3330 Root canal - endodontic therapy, molar (excluding final restoration) | \$310.00 |
| D2932 Prefabricated resin crown - anterior primary tooth | \$45.00 | D3331 Treatment of root canal obstruction; non-surgical access | \$85.00 |
| D2933 Prefabricated stainless steel crown with resin window - anterior primary tooth | \$45.00 | D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | \$110.00 |
| D2940 Protective restoration | \$0.00 | D3333 Internal root repair of perforation defects | \$85.00 |
| D2941 Interim therapeutic restoration – primary dentition | \$0.00 | D3346 Retreatment of previous root canal therapy - anterior | \$230.00 |
| D2949 Restorative foundation for an indirect restoration | \$60.00 | D3347 Retreatment of previous root canal therapy - bicuspid | \$280.00 |
| D2950 Core buildup, including any pins when required | \$60.00 | D3348 Retreatment of previous root canal therapy - molar | \$325.00 |
| D2951 Pin retention - per tooth, in addition to restoration | \$10.00 | D3351 Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | \$70.00 |
| D2952 Cast post and core in addition to crown, indirectly fabricated - includes canal preparation | \$60.00 | D3352 Apexification/recalcification - interim medication replacement | \$70.00 |
| D2953 Each additional indirectly fabricated post - same tooth - includes canal preparation | \$60.00 | D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.) | \$70.00 |
| D2954 Prefabricated post and core in addition to crown - base metal post; includes canal preparation | \$30.00 | D3410 Apicoectomy - anterior | \$190.00 |
| D2955 Post removal | \$10.00 | D3421 Apicoectomy - bicuspid (first root) | \$95.00 |
| D2957 Each additional prefabricated post - same tooth - base metal post; includes canal preparation | \$30.00 | D3425 Apicoectomy - molar (first root) | \$95.00 |
| D2960 Labial veneer (resin laminate) - chairside | \$250.00 | D3426 Apicoectomy (each additional root) | \$80.00 |
| D2961 Labial veneer (resin laminate) – laboratory | \$300.00 | D3427 Periradicular surgery without apicoectomy | \$190.00 |
| D2962 Labial Veneer (Porcelain Laminate)--Lab | \$350.00 | D3430 Retrograde filling - per root | \$60.00 |
| D2970 Temporary crown (fractured tooth) - palliative treatment only | \$0.00 | D3450 Root amputation, per root | \$110.00 |
| D2971 Additional procedures to construct new crown under existing partial denture framework | \$50.00 | D3910 Surgical procedure for isolation of tooth with rubber dam | \$19.00 |
| D2980 Crown repair necessitated by restorative material failure | \$0.00 | D3920 Hemisection (including any root removal), not including root canal therapy | \$90.00 |
| D2981 Inlay repair necessitated by restorative material failure | \$0.00 | D3950 Canal preparation and fitting of preformed dowel or post | \$15.00 |
| D2982 Onlay repair necessitated by restorative material failure | \$0.00 | | |
| D2983 Veneer repair necessitated by restorative material failure | \$0.00 | | |
| D2990 Resin infiltration of incipient smooth surface lesions | \$0.00 | | |
| D3000-D3999 | | IV. ENDODONTICS | |
| D3110 Pulp cap - direct (excluding final restoration) | \$5.00 | D4000-D4999 | V. PERIODONTICS |
| D3120 Pulp cap - indirect (excluding final restoration) | \$5.00 | - Includes preoperative and postoperative evaluations and treatment under a local anesthetic. | |
| D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | \$40.00 | - Periodontal maintenance copay includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction. | |
| D3221 Pulpal debridement, primary and permanent teeth | \$60.00 | | |
| D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development | \$40.00 | D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | \$180.00 |
| D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | \$40.00 | D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | \$55.00 |
| D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | \$40.00 | | |

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DeltaCare® USA (DHMO)

Standard Plan

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| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | \$55.00 | D4910 | Periodontal maintenance - limited to 2 treatments per year | \$50.00 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | \$170.00 | D4910 | Additional periodontal maintenance - beyond 2 per year | \$60.00 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | \$130.00 | D4921 | Gingival irrigation - per quadrant | \$0.00 |
| D4245 | Apically positioned flap | \$165.00 | D5000-D5899 | | VI. PROSTHODONTICS (removable) |
| D4249 | Clinical crown lengthening - hard tissue | \$160.00 | - For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered. | | |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | \$330.00 | - Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. | | |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | \$248.00 | - Replacement of a denture or a partial denture requires the existing denture to be 5+ years old. | | |
| D4263 | Bone replacement graft - first site in quadrant | \$180.00 | D5110 | Complete denture - maxillary | \$375.00 |
| D4264 | Bone replacement graft - each additional site in quadrant | \$95.00 | D5120 | Complete denture - mandibular | \$375.00 |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | \$95.00 | D5130 | Immediate denture - maxillary | \$375.00 |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | \$215.00 | D5140 | Immediate denture - mandibular | \$375.00 |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) | \$255.00 | D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | \$375.00 |
| D4270 | Pedicle soft tissue graft procedure | \$250.00 | D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | \$375.00 |
| D4273 | Subepithelial connective tissue graft procedures, per tooth | \$75.00 | D5213 | Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) | \$375.00 |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | \$100.00 | D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$375.00 |
| D4275 | Soft tissue allograft | \$380.00 | D5225 | Maxillary partial denture - flexible base (including any clasps, rests and teeth) | \$480.00 |
| D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | \$260.00 | D5226 | Mandibular partial denture - flexible base (including any clasps, rests and teeth) | \$480.00 |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | \$260.00 | D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | \$360.00 |
| D4320 | Provisional splinting - intracoronal | \$95.00 | D5410 | Adjust complete denture - maxillary | \$20.00 |
| D4321 | Provisional splinting - extracoronal | \$85.00 | D5411 | Adjust complete denture - mandibular | \$20.00 |
| D4341 | Periodontal scaling and root planing, four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months | \$60.00 | D5421 | Adjust partial denture - maxillary | \$20.00 |
| D4342 | Periodontal scaling and root planing, one to three teeth, per quadrant - limited to 4 quadrants during any 12 consecutive months | \$45.00 | D5422 | Adjust partial denture - mandibular | \$20.00 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months | \$50.00 | D5510 | Repair broken complete denture base | \$30.00 |
| D4381 | Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth | \$60.00 | D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$30.00 |
| | | | D5610 | Repair resin denture base | \$30.00 |
| | | | D5620 | Repair cast framework | \$50.00 |
| | | | D5630 | Repair or replace broken clasp | \$30.00 |
| | | | D5640 | Replace broken teeth - per tooth | \$30.00 |
| | | | D5650 | Add tooth to existing partial denture | \$45.00 |
| | | | D5660 | Add clasp to existing partial denture | \$70.00 |

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| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$165.00 | D6241 | Pontic - porcelain fused to predominantly base metal | \$370.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$165.00 | D6242 | Pontic - porcelain fused to noble metal | \$370.00 |
| D5710 | Rebase complete maxillary denture | \$125.00 | D6245 | Pontic - porcelain/ceramic | \$370.00 |
| D5711 | Rebase complete mandibular denture | \$125.00 | D6250 | Pontic - resin with high noble metal | \$370.00 |
| D5720 | Rebase maxillary partial denture | \$125.00 | D6251 | Pontic - resin with predominantly base metal | \$370.00 |
| D5721 | Rebase mandibular partial denture | \$125.00 | D6252 | Pontic - resin with noble metal | \$370.00 |
| D5730 | Reline complete maxillary denture (chairside) | \$65.00 | D6253 | Provisional pontic | \$0.00 |
| D5731 | Reline complete mandibular denture (chairside) | \$65.00 | D6545 | Retainer – cast metal for resin bonded fixed prosthesis | \$370.00 |
| D5740 | Reline maxillary partial denture (chairside) | \$65.00 | D6549 | Resin retainer - for resin bonded fixed prosthesis | \$370.00 |
| D5741 | Reline mandibular partial denture (chairside) | \$65.00 | D6600 | Inlay - porcelain/ceramic, two surfaces | \$370.00 |
| D5750 | Reline complete maxillary denture (laboratory) | \$50.00 | D6601 | Inlay - porcelain/ceramic, three or more surfaces | \$370.00 |
| D5751 | Reline complete mandibular denture (laboratory) | \$50.00 | D6602 | Inlay - cast high noble metal, two surfaces | \$370.00 |
| D5760 | Reline maxillary partial denture (laboratory) | \$50.00 | D6603 | Inlay - cast high noble metal, three or more surfaces | \$370.00 |
| D5761 | Reline mandibular partial denture (laboratory) | \$50.00 | D6604 | Inlay - cast predominantly base metal, two surfaces | \$370.00 |
| D5810 | Interim complete denture (maxillary) | \$230.00 | D6605 | Inlay - cast predominantly base metal, three or more surfaces | \$370.00 |
| D5811 | Interim complete denture (mandibular) | \$230.00 | D6606 | Inlay - cast noble metal, two surfaces | \$370.00 |
| D5820 | Interim partial denture (maxillary) - limited to 1 in any 12 consecutive months | \$160.00 | D6607 | Inlay - cast noble metal, three or more surfaces | \$370.00 |
| D5821 | Interim partial denture (mandibular) - limited to 1 in any 12 consecutive months | \$170.00 | D6608 | Onlay - porcelain/ceramic, two surfaces | \$370.00 |
| D5850 | Tissue conditioning, maxillary | \$40.00 | D6609 | Onlay - porcelain/ceramic, three or more surfaces | \$370.00 |
| D5851 | Tissue conditioning, mandibular | \$40.00 | D6610 | Onlay - cast high noble metal, two surfaces | \$370.00 |
| D5862 | Precision attachment, by report | \$160.00 | D6611 | Onlay - cast high noble metal, three or more surfaces | \$370.00 |
| D5900-D5999 | VII. MAXILLOFACIAL PROSTHETICS | - Not Covered | D6612 | Onlay - cast predominantly base metal, two surfaces | \$370.00 |
| D6000-D6199 | VIII. IMPLANT SERVICES | - Not Covered | D6613 | Onlay - cast predominantly base metal, three or more surfaces | \$370.00 |
| D6200-D6999 | IX. PROSTHODONTICS, FIXED | (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)) | D6614 | Onlay - cast noble metal, two surfaces | \$370.00 |
| | | <ul style="list-style-type: none">- An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no copayment per crown/bridge unit in addition to regular copayments for porcelain on molars.- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$125.00 per unit, beyond the 6th unit.- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old. | D6615 | Onlay - cast noble metal, three or more surfaces | \$370.00 |
| D6210 | Pontic - cast high noble metal | \$370.00 | D6710 | Crown – indirect resin based composite | \$370.00 |
| D6211 | Pontic - cast predominantly base metal | \$370.00 | D6720 | Crown - resin with high noble metal | \$370.00 |
| D6212 | Pontic - cast noble metal | \$370.00 | D6721 | Crown - resin with predominantly base metal | \$370.00 |
| D6214 | Pontic - titanium | \$370.00 | D6722 | Crown - resin with noble metal | \$370.00 |
| D6240 | Pontic - porcelain fused to high noble metal | \$370.00 | D6740 | Crown - porcelain/ceramic | \$370.00 |
| | | | D6750 | Crown - porcelain fused to high noble metal | \$370.00 |
| | | | D6751 | Crown - porcelain fused to predominantly base metal | \$370.00 |
| | | | D6752 | Crown - porcelain fused to noble metal | \$370.00 |
| | | | D6780 | Crown - ¾ cast high noble metal | \$370.00 |
| | | | D6781 | Crown - ¾ cast predominantly base metal | \$370.00 |
| | | | D6782 | Crown - ¾ cast noble metal | \$370.00 |
| | | | D6783 | Crown - ¾ porcelain/ceramic | \$370.00 |
| | | | D6790 | Crown - full cast high noble metal | \$370.00 |
| | | | D6791 | Crown - full cast predominantly base metal | \$370.00 |
| | | | D6792 | Crown - full cast noble metal | \$370.00 |
| | | | D6794 | Crown - titanium | \$370.00 |
| | | | D6930 | Re-cement or re-bond fixed partial denture | \$15.00 |
| | | | D6940 | Stress breaker | \$110.00 |
| | | | D6950 | Precision attachment | \$195.00 |

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D6980 Fixed partial denture repair necessitated by restorative material failure \$45.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111 Extraction, coronal remnants - deciduous tooth \$20.00

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) \$20.00

D7210 surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated \$50.00

D7220 Removal of impacted tooth - soft tissue \$75.00

D7230 Removal of impacted tooth - partially bony \$85.00

D7240 Removal of impacted tooth - completely bony \$135.00

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications \$150.00

D7250 Surgical removal of residual tooth roots (cutting procedure) \$65.00

D7251 Coronectomy – intentional partial tooth removal \$150.00

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth \$80.00

D7280 Surgical access of an unerupted tooth \$100.00

D7282 Mobilization of erupted or malpositioned tooth to aid eruption \$90.00

D7283 Placement of device to facilitate eruption of impacted tooth \$90.00

D7285 Incisional biopsy of oral tissue-hard (bone, tooth) - does not include pathology laboratory procedures \$150.00

D7286 Incisional biopsy of oral tissue-soft - does not include pathology laboratory procedures \$60.00

D7287 Exfoliative cytological sample collection \$50.00

D7288 Brush biopsy - transepithelial sample collection \$50.00

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant \$45.00

D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant \$25.00

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant \$100.00

D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant \$65.00

D7471 Removal of lateral exostosis - (maxilla or mandible) \$80.00

D7472 Removal of torus palatinus \$60.00

D7473 Removal of torus mandibularis \$60.00

D7485 Surgical reduction of osseous tuberosity \$60.00

D7510 Incision and drainage of abscess - intraoral soft tissue \$35.00

D7511 Incision and drainage of abscess - intraoral soft tissue - complicated \$35.00

D7520 Incision and drainage of abscess – extraoral soft tissue \$35.00

D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) \$35.00

D7910 Suture of Recent Small Wounds up to 5cm \$25.00

D7960 Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure \$90.00

D7963 Frenuloplasty \$90.00

D7970 Excision hyperplastic tissue - per arch \$55.00

D7971 Excision of pericoronal gingiva \$40.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$25.00, may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months. Pre and post orthodontic records include:

Pre- and post-orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$0.00

D0210 Intraoral - complete series (including bitewings)

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 Cephalometric radiographic image

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: \$0.00

D0210 Intraoral - complete series (including bitewings)

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition \$1,095.00

D8020 Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19 \$1,095.00

D8030 Limited orthodontic treatment of the adolescent dentition - adolescent to age 19 \$1,095.00

D8040 Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children \$1,095.00

D8050 Interceptive orthodontic treatment of the primary dentition 25% Discount

D8060 Interceptive orthodontic treatment of the transitional dentition 25% Discount

D8070 Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 \$2,095.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 \$2,095.00

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.



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| | | |
|-------|--|--------------|
| D8090 | Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> | \$2,095.00 |
| D8210 | Removable appliance therapy | 25% Discount |
| D8220 | Fixed appliance therapy | 25% Discount |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | \$35.00 |
| D8670 | Periodic orthodontic treatment visit | \$0.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of removable retainers) | \$300.00 |
| D8693 | Re-bond or re-cement fixed retainer | \$0.00 |
| D8694 | Repair of fixed retainers, includes reattachment - <i>limited to 2 per 6 month period</i> | \$0.00 |
| D8999 | Unspecified orthodontic procedure, by report - includes treatment planning session | \$250.00 |

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

| | | |
|-------|---|----------|
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | \$15.00 |
| D9120 | Fixed partial denture sectioning | \$0.00 |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | \$0.00 |
| D9211 | Regional block anesthesia | \$0.00 |
| D9212 | Trigeminal division block anesthesia | \$0.00 |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | \$0.00 |
| D9219 | Evaluation for deep sedation or general anesthesia | \$0.00 |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | \$150.00 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | \$45.00 |
| D9230 | Inhalation of nitrous oxide/anoxiolysis, analgesia | \$15.00 |
| D9241 | Intravenous moderate (conscious) sedation/analgesia - first 30 minutes | \$150.00 |
| D9242 | Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes | \$45.00 |
| D9248 | Non-intravenous moderate (conscious) sedation | \$15.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | \$5.00 |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | \$0.00 |
| D9440 | Office visit - after regularly scheduled hours | \$30.00 |
| D9450 | Case presentation, detailed and extensive treatment planning | \$0.00 |
| D9610 | Therapeutic parenteral drug, single administration | \$15.00 |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | \$25.00 |
| D9630 | Other drugs and/or medicaments, by report | \$15.00 |
| D9910 | Application of desensitizing medicament | \$15.00 |

| | | |
|-------|---|----------|
| D9931 | Cleaning and inspection of a removable appliance | \$0.00 |
| D9940 | Occlusal guard, by report - <i>limited to 1 in 3 years</i> | \$85.00 |
| D9942 | Repair and/or relining of occlusal guard | \$40.00 |
| D9951 | Occlusal adjustment, limited | \$25.00 |
| D9952 | Occlusal adjustment, complete | \$100.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays | \$125.00 |
| D9986 | Missed appointment - <i>without 24 hour notice</i> | \$25.00 |
| D9987 | Canceled appointment - <i>without 24 hour notice</i> | \$25.00 |

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. During the course of treatment, your Contract Dentist may recommend the services of a dental specialist. Your Contract Dentist may refer you directly to a Contract Specialist; referral approval from Delta Dental is not required. However, certain procedures may require pre-treatment authorization prior to care. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 1.800.693.2589.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
2. Any procedures not specifically listed as a covered benefit in this Plan's Schedule A are available at 75% of the filed fees of the Enrollee's selected Contract Dentist or Contract Specialist, provided the services are included in the treatment plan and are not specifically excluded.
3. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the filed fees of the Enrollee's selected Contract Dentist or Contract Specialist, unless specifically listed as a covered benefit on Schedule A.
4. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$25.00 above the listed Copayment for each of these services after the sixth unit has been provided.
5. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).



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6. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of the Enrollee's selected Contract Dentist or Contract Specialist's filed fees.
7. Benefits provided by a pediatric Dentist are limited to children, through the end of the month that the dependent child turns age eight.
8. The cost to an Enrollee receiving orthodontic treatment whose coverage is canceled or terminated for any reason will be based on the Contract Orthodontist's filed fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
9. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
- abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations or other diagnostic services for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist or Contract Orthodontist) except for Emergency Services as described in the Contract and/or Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Over-the-counter drugs; prescription drugs not administered by the Enrollee's selected Contract Dentist or Contract Specialist.
12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

Exclusions of Benefits

1. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
2. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) with the exception of procedures D9951 and D9952 as shown on Schedule A.
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision
13. Changes in orthodontic treatment necessitated by accident of any kind.
14. Myofunctional and parafunctional appliances and/or therapies.
15. Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
17. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
18. Dental services required while serving in the Armed Forces or any country or international authority.
19. Dental services considered experimental in nature.
20. Orthognathic surgery.
21. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the Enrollee's dental health, as determined by the DeltaCare USA Contract Dentist.
22. Treatment of malignancies, cysts, or neoplasms unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.



DeltaCare® USA (DHMO)

High Plan

SCHEDULE A

Description of Benefits and Copayments High Plan

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

All non-listed services are available with your selected Contract Dentist or Contract Specialist at 75% of their filed fees.

| Code | Description | Enrollee Pays | | |
|--------------------|---|---------------|----------------------|--|
| D0100-D0999 | | | I. DIAGNOSTIC | |
| D0120 | Periodic oral evaluation - established patient | \$0.00 | D0415 | Collection of microorganisms for culture and sensitivity \$0.00 |
| D0140 | Limited oral evaluation - problem focused | \$0.00 | D0425 | Caries susceptibility tests \$0.00 |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | \$0.00 | D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures \$50.00 |
| D0150 | Comprehensive oral evaluation - new or established patient | \$0.00 | D0460 | Pulp vitality tests \$0.00 |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | \$0.00 | D0470 | Diagnostic casts \$0.00 |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | \$0.00 | D0472 | Accession of tissue, gross examination, preparation and transmission of written report. \$0.00 |
| D0171 | Re-evaluation – post-operative office visit | \$0.00 | D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report. \$0.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | \$10.00 | D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.\$0.00 |
| D0190 | Screening of a patient | \$0.00 | D0486 | Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report \$0.00 |
| D0191 | Assessment of a patient | \$0.00 | D0601 | Caries risk assessment and documentation, with a finding of low risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0210 | Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i> | \$0.00 | D0602 | Caries risk assessment and documentation, with a finding of moderate risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0220 | Intraoral - periapical first radiographic image | \$0.00 | D0603 | Caries risk assessment and documentation, with a finding of high risk - <i>limited to children age 3 to 19, 1 every 3 years</i> \$0.00 |
| D0230 | Intraoral - periapical, each additional radiographic image | \$0.00 | D0999 | Unspecified diagnostic procedure, by report - <i>includes office visit, per visit including all fees for sterilization and/or infection control (in addition to other services)</i> \$5.00 |
| D0240 | Intraoral - occlusal radiographic image | \$0.00 | D1000-D1999 | II. PREVENTIVE |
| D0250 | Extraoral - first radiographic image | \$0.00 | D1110 | Prophylaxis cleaning - adult - 2 per year \$0.00 |
| D0260 | Extraoral - each additional radiographic image | \$0.00 | D1110 | <i>Additional prophylaxis cleaning - adult; 2 within year</i> \$20.00 |
| D0270 | Bitewing radiograph - single radiographic image | \$0.00 | | |
| D0272 | Bitewings radiographs - two radiographic images | \$0.00 | | |
| D0273 | Bitewings - radiographs - three radiographic images | \$0.00 | | |
| D0274 | Bitewings radiographs - four radiographic images - <i>limited to 1 series every 6 months</i> | \$0.00 | | |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | \$0.00 | | |
| D0330 | Panoramic radiographic image | \$0.00 | | |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally | \$0.00 | | |
| D0351 | 3D photographic image | \$0.00 | | |

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High Plan

| | | | | | |
|-------|---|---------|-------|---|----------|
| D1120 | Prophylaxis cleaning - child - 2 per year | \$0.00 | D2393 | Resin-based composite - three surfaces, posterior | \$90.00 |
| D1120 | <i>Additional prophylaxis cleaning - child; 2 within year</i> | \$20.00 | D2394 | Resin-based composite - four or more surfaces, posterior | \$120.00 |
| D1206 | Topical application of fluoride varnish - 2 per year; 2 D1206 or D1208 per year | \$0.00 | D2510 | Inlay - metallic - one surface | \$95.00 |
| D1208 | Topical application of fluoride - excluding varnish - 2 per year; 2 D1206 or D1208 per year | \$0.00 | D2520 | Inlay - metallic - two surfaces | \$105.00 |
| D1310 | Nutritional counseling for control of dental disease. | \$0.00 | D2530 | Inlay - metallic - three or more surfaces | \$130.00 |
| D1320 | Tobacco counseling for the control and prevention of oral disease | \$0.00 | D2542 | Onlay - metallic - two surfaces | \$230.00 |
| D1330 | Oral hygiene instructions | \$0.00 | D2543 | Onlay - metallic - three surfaces | \$230.00 |
| D1351 | Sealant - per tooth - <i>limited to permanent molars through age 15</i> | \$5.00 | D2544 | Onlay - metallic - four or more surfaces | \$230.00 |
| D1352 | Preventive resin restoration in a moderate to high carries risk patient - permanent tooth | \$5.00 | D2610 | Inlay - porcelain/ceramic - one surface | \$230.00 |
| D1353 | Sealant repair - per tooth - <i>limited to permanent molars through age 15</i> | \$5.00 | D2620 | Inlay - porcelain/ceramic - two surfaces | \$230.00 |
| D1510 | Space maintainer - fixed - unilateral | \$45.00 | D2630 | Inlay - porcelain/ceramic - three or more surfaces | \$230.00 |
| D1515 | Space maintainer - fixed - bilateral | \$45.00 | D2642 | Onlay - porcelain/ceramic - two surfaces | \$230.00 |
| D1520 | Space maintainer - removable - unilateral | \$85.00 | D2643 | Onlay - porcelain/ceramic - three surfaces | \$230.00 |
| D1525 | Space maintainer - removable - bilateral | \$85.00 | D2644 | Onlay - porcelain/ceramic - four or more surfaces | \$230.00 |
| D1550 | Re-cement or re-bond space maintainer | \$5.00 | D2650 | Inlay - resin-based composite - one surface | \$230.00 |
| D1555 | Removal of fixed space maintainer | \$5.00 | D2651 | Inlay - resin-based composite - two surfaces | \$230.00 |
| | | | D2652 | Inlay - resin-based composite - three or more surfaces | \$230.00 |
| | | | D2662 | Onlay - resin-based composite - two surfaces | \$230.00 |
| | | | D2663 | Onlay - resin-based composite - three surfaces | \$230.00 |
| | | | D2664 | Onlay - resin-based composite - four or more surfaces | \$230.00 |
| | | | D2710 | Crown - resin (indirect) | \$230.00 |
| | | | D2712 | Crown - ¾ resin-based composite (indirect) | \$230.00 |
| | | | D2720 | Crown - resin with high noble metal | \$230.00 |
| | | | D2721 | Crown - resin with predominantly base metal | \$230.00 |
| | | | D2722 | Crown - resin with noble metal | \$230.00 |
| | | | D2740 | Crown - porcelain/ceramic substrate | \$280.00 |
| | | | D2750 | Crown - porcelain fused to high noble metal | \$280.00 |
| | | | D2751 | Crown - porcelain fused to predominantly base metal | \$280.00 |
| | | | D2752 | Crown - porcelain fused to noble metal | \$280.00 |
| | | | D2780 | Crown - ¾ cast high noble metal | \$230.00 |
| | | | D2781 | Crown - ¾ cast predominantly base metal | \$230.00 |
| | | | D2782 | Crown - ¾ cast noble metal | \$230.00 |
| | | | D2783 | Crown - ¾ porcelain/ceramic | \$230.00 |
| | | | D2790 | Crown - full cast high noble metal | \$280.00 |
| | | | D2791 | Crown - full cast predominantly base metal | \$280.00 |
| | | | D2792 | Crown - full cast noble metal | \$280.00 |
| | | | D2794 | Crown - titanium | \$230.00 |
| | | | D2799 | Provisional crown | \$0.00 |
| | | | D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | \$10.00 |
| | | | D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | \$0.00 |
| | | | D2920 | Re-cement or re-bond crown | \$10.00 |
| | | | D2921 | Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>) | \$55.00 |

D2000-D2999

III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no copayment per crown unit in addition to regular copayments for porcelain on molars.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$125.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

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| D2140 | Amalgam - one surface, primary or permanent | \$0.00 |
| D2150 | Amalgam - two surfaces, primary or permanent | \$0.00 |
| D2160 | Amalgam - three surfaces, primary or permanent | \$0.00 |
| D2161 | Amalgam - four or more surfaces, primary or permanent | \$0.00 |
| D2330 | Resin-based composite - one surface, anterior | \$35.00 |
| D2331 | Resin-based composite - two surfaces, anterior | \$40.00 |
| D2332 | Resin-based composite - three surfaces, anterior | \$50.00 |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | \$55.00 |
| D2390 | Resin-based composite crown, anterior | \$70.00 |
| D2391 | Resin-based composite - one surface, posterior | \$60.00 |
| D2392 | Resin-based composite - two surfaces, posterior | \$80.00 |

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| D2929 Prefabricated porcelain/ceramic crown – (anterior) primary tooth | \$35.00 | D3310 Root canal - endodontic therapy, anterior tooth (excluding final restoration) | \$80.00 |
| D2930 Prefabricated stainless steel crown - primary tooth | \$25.00 | D3320 Root canal - endodontic therapy, bicuspid tooth (excluding final restoration) | \$115.00 |
| D2931 Prefabricated stainless steel crown - permanent tooth | \$25.00 | D3330 Root canal - endodontic therapy, molar (excluding final restoration) | \$200.00 |
| D2932 Prefabricated resin crown - anterior primary tooth | \$35.00 | D3331 Treatment of root canal obstruction; non-surgical access | \$85.00 |
| D2933 Prefabricated stainless steel crown with resin window - anterior primary tooth | \$35.00 | D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | \$70.00 |
| D2940 Protective restoration | \$10.00 | D3333 Internal root repair of perforation defects | \$85.00 |
| D2941 Interim therapeutic restoration – primary dentition | \$10.00 | D3346 Retreatment of previous root canal therapy - anterior | \$135.00 |
| D2949 Restorative foundation for an indirect restoration | \$45.00 | D3347 Retreatment of previous root canal therapy - bicuspid | \$175.00 |
| D2950 Core buildup, including any pins when required | \$45.00 | D3348 Retreatment of previous root canal therapy - molar | \$275.00 |
| D2951 Pin retention - per tooth, in addition to restoration | \$10.00 | D3351 Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | \$65.00 |
| D2952 Cast post and core in addition to crown, indirectly fabricated - includes canal preparation | \$60.00 | D3352 Apexification/recalcification - interim medication replacement | \$65.00 |
| D2953 Each additional indirectly fabricated post - same tooth - includes canal preparation | \$60.00 | D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | \$65.00 |
| D2954 Prefabricated post and core in addition to crown - base metal post; includes canal preparation | \$60.00 | D3410 Apicoectomy - anterior | \$95.00 |
| D2955 Post removal | \$10.00 | D3421 Apicoectomy - bicuspid (first root) | \$95.00 |
| D2957 Each additional prefabricated post - same tooth - base metal post; includes canal preparation | \$30.00 | D3425 Apicoectomy - molar (first root) | \$95.00 |
| D2960 Labial veneer (resin laminate) - chairside | \$250.00 | D3426 Apicoectomy (each additional root) | \$60.00 |
| D2961 Labial veneer (resin laminate) – laboratory | \$300.00 | D3427 Periradicular surgery without apicoectomy | \$95.00 |
| D2962 Labial Veneer (Porcelain Laminate)--Lab | \$350.00 | D3430 Retrograde filling - per root | \$40.00 |
| D2970 Temporary crown (fractured tooth) - palliative treatment only | \$0.00 | D3450 Root amputation, per root | \$95.00 |
| D2971 Additional procedures to construct new crown under existing partial denture framework | \$50.00 | D3910 Surgical procedure for isolation of tooth with rubber dam | \$19.00 |
| D2980 Crown repair necessitated by restorative material failure | \$0.00 | D3920 Hemisection (including any root removal), not including root canal therapy | \$90.00 |
| D2981 Inlay repair necessitated by restorative material failure | \$0.00 | D3950 Canal preparation and fitting of preformed dowel or post | \$15.00 |
| D2982 Onlay repair necessitated by restorative material failure | \$0.00 | | |
| D2983 Veneer repair necessitated by restorative material failure | \$0.00 | | |
| D2990 Resin infiltration of incipient smooth surface lesions | \$5.00 | | |

D3000-D3999

IV. ENDODONTICS

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| D3110 Pulp cap - direct (excluding final restoration) | \$0.00 |
| D3120 Pulp cap - indirect (excluding final restoration) | \$0.00 |
| D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | \$10.00 |
| D3221 Pulpal debridement, primary and permanent teeth | \$45.00 |
| D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development | \$10.00 |
| D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | \$30.00 |
| D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | \$35.00 |

D4000-D4999

V. PERIODONTICS

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| - Includes preoperative and postoperative evaluations and treatment under a local anesthetic. | |
| - Periodontal maintenance copay includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction. | |
| D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | \$125.00 |
| D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | \$40.00 |
| D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | \$40.00 |

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| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | \$150.00 | D4910 | Periodontal maintenance - limited to 2 treatments per year | \$30.00 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | \$113.00 | D4910 | Additional periodontal maintenance - beyond 2 per year | \$55.00 |
| D4245 | Apically positioned flap | \$165.00 | D4921 | Gingival irrigation – per quadrant | \$0.00 |
| D4249 | Clinical crown lengthening - hard tissue | \$120.00 | | | |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | \$295.00 | D5000-D5899 | VI. PROSTHODONTICS (removable) | |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | \$210.00 | | - For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered. | |
| D4263 | Bone replacement graft - first site in quadrant | \$180.00 | | - Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. | |
| D4264 | Bone replacement graft - each additional site in quadrant | \$95.00 | | - Replacement of a denture or a partial denture requires the existing denture to be 5+ years old. | |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | \$95.00 | D5110 | Complete denture - maxillary | \$210.00 |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | \$215.00 | D5120 | Complete denture - mandibular | \$210.00 |
| D4267 | Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal) | \$255.00 | D5130 | Immediate denture - maxillary | \$225.00 |
| D4270 | Pedicle soft tissue graft procedure | \$245.00 | D5140 | Immediate denture - mandibular | \$225.00 |
| D4273 | Subepithelial connective tissue graft procedures, per tooth | \$75.00 | D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | \$240.00 |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | \$70.00 | D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | \$240.00 |
| D4275 | Soft tissue allograft | \$380.00 | D5213 | Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) | \$260.00 |
| D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | \$245.00 | D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$260.00 |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | \$245.00 | D5225 | Maxillary partial denture - flexible base (including any clasps, rests and teeth) | \$365.00 |
| D4320 | Provisional splinting – intracoronal | \$95.00 | D5226 | Mandibular partial denture - flexible base (including any clasps, rests and teeth) | \$365.00 |
| D4321 | Provisional splinting – extracoronal | \$85.00 | D5281 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth) | \$250.00 |
| D4341 | Periodontal scaling and root planing, four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months | \$40.00 | D5410 | Adjust complete denture - maxillary | \$0.00 |
| D4342 | Periodontal scaling and root planing, one to three teeth, per quadrant - limited to 4 quadrants during any 12 consecutive months | \$30.00 | D5411 | Adjust complete denture - mandibular | \$0.00 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months | \$40.00 | D5421 | Adjust partial denture - maxillary | \$0.00 |
| D4381 | Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth | \$45.00 | D5422 | Adjust partial denture - mandibular | \$0.00 |
| | | | D5510 | Repair broken complete denture base | \$15.00 |
| | | | D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$15.00 |
| | | | D5610 | Repair resin denture base | \$15.00 |
| | | | D5620 | Repair cast framework | \$30.00 |
| | | | D5630 | Repair or replace broken clasp | \$15.00 |
| | | | D5640 | Replace broken teeth - per tooth | \$15.00 |
| | | | D5650 | Add tooth to existing partial denture | \$30.00 |
| | | | D5660 | Add clasp to existing partial denture | \$35.00 |

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| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$165.00 | D6242 | Pontic - porcelain fused to noble metal | \$280.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$165.00 | D6245 | Pontic - porcelain/ceramic | \$250.00 |
| D5710 | Rebase complete maxillary denture | \$60.00 | D6250 | Pontic - resin with high noble metal | \$230.00 |
| D5711 | Rebase complete mandibular denture | \$60.00 | D6251 | Pontic - resin with predominantly base metal | \$230.00 |
| D5720 | Rebase maxillary partial denture | \$60.00 | D6252 | Pontic - resin with noble metal | \$230.00 |
| D5721 | Rebase mandibular partial denture | \$60.00 | D6253 | Provisional pontic | \$0.00 |
| D5730 | Reline complete maxillary denture (chairside) | \$35.00 | D6545 | Retainer – cast metal for resin bonded fixed prosthesis | \$200.00 |
| D5731 | Reline complete mandibular denture (chairside) | \$35.00 | D6549 | Resin retainer - for resin bonded fixed prosthesis | \$200.00 |
| D5740 | Reline maxillary partial denture (chairside) | \$35.00 | D6600 | Inlay - porcelain/ceramic, two surfaces | \$230.00 |
| D5741 | Reline mandibular partial denture (chairside) | \$35.00 | D6601 | Inlay - porcelain/ceramic, three or more surfaces | \$230.00 |
| D5750 | Reline complete maxillary denture (laboratory) | \$35.00 | D6602 | Inlay - cast high noble metal, two surfaces | \$230.00 |
| D5751 | Reline complete mandibular denture (laboratory) | \$35.00 | D6603 | Inlay - cast high noble metal, three or more surfaces | \$230.00 |
| D5760 | Reline maxillary partial denture (laboratory) | \$35.00 | D6604 | Inlay - cast predominantly base metal, two surfaces | \$230.00 |
| D5761 | Reline mandibular partial denture (laboratory) | \$35.00 | D6605 | Inlay - cast predominantly base metal, three or more surfaces | \$230.00 |
| D5810 | Interim complete denture (maxillary) | \$230.00 | D6606 | Inlay - cast noble metal, two surfaces | \$230.00 |
| D5811 | Interim complete denture (mandibular) | \$230.00 | D6607 | Inlay - cast noble metal, three or more surfaces | \$230.00 |
| D5820 | Interim partial denture (maxillary) - limited to 1 in any 12 consecutive months | \$60.00 | D6608 | Onlay - porcelain/ceramic, two surfaces | \$230.00 |
| D5821 | Interim partial denture (mandibular) - limited to 1 in any 12 consecutive months | \$60.00 | D6609 | Onlay - porcelain/ceramic, three or more surfaces | \$230.00 |
| D5850 | Tissue conditioning, maxillary | \$30.00 | D6610 | Onlay - cast high noble metal, two surfaces | \$230.00 |
| D5851 | Tissue conditioning, mandibular | \$30.00 | D6611 | Onlay - cast high noble metal, three or more surfaces | \$230.00 |
| D5862 | Precision attachment, by report | \$160.00 | D6612 | Onlay - cast predominantly base metal, two surfaces | \$230.00 |
| D5900-D5999 | VII. MAXILLOFACIAL PROSTHETICS | - Not Covered | D6613 | Onlay - cast predominantly base metal, three or more surfaces | \$230.00 |
| D6000-D6199 | VIII. IMPLANT SERVICES | - Not Covered | D6614 | Onlay - cast noble metal, two surfaces | \$230.00 |
| D6200-D6999 | IX. PROSTHODONTICS, FIXED | (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)) | D6615 | Onlay - cast noble metal, three or more surfaces | \$230.00 |
| | - An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no copayment per crown/bridge unit in addition to regular copayments for porcelain on molars. | | D6710 | Crown – indirect resin based composite | \$230.00 |
| | - When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$125.00 per unit, beyond the 6th unit. | | D6720 | Crown - resin with high noble metal | \$230.00 |
| | - Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old. | | D6721 | Crown - resin with predominantly base metal | \$230.00 |
| D6210 | Pontic - cast high noble metal | \$280.00 | D6722 | Crown - resin with noble metal | \$230.00 |
| D6211 | Pontic - cast predominantly base metal | \$280.00 | D6740 | Crown - porcelain/ceramic | \$230.00 |
| D6212 | Pontic - cast noble metal | \$280.00 | D6750 | Crown - porcelain fused to high noble metal | \$230.00 |
| D6214 | Pontic - titanium | \$280.00 | D6751 | Crown - porcelain fused to predominantly base metal | \$230.00 |
| D6240 | Pontic - porcelain fused to high noble metal | \$280.00 | D6752 | Crown - porcelain fused to noble metal | \$230.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | \$280.00 | D6780 | Crown - ¾ cast high noble metal | \$230.00 |
| | | | D6781 | Crown - ¾ cast predominantly base metal | \$230.00 |
| | | | D6782 | Crown - ¾ cast noble metal | \$230.00 |
| | | | D6783 | Crown - ¾ porcelain/ceramic | \$230.00 |
| | | | D6790 | Crown - full cast high noble metal | \$230.00 |
| | | | D6791 | Crown - full cast predominantly base metal | \$230.00 |
| | | | D6792 | Crown - full cast noble metal | \$230.00 |
| | | | D6794 | Crown - titanium | \$230.00 |
| | | | D6930 | Re-cement or re-bond fixed partial denture | \$0.00 |
| | | | D6940 | Stress breaker | \$110.00 |
| | | | D6950 | Precision attachment | \$195.00 |
| | | | D6980 | Fixed partial denture repair necessitated by restorative material failure | \$45.00 |

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D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

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| D7111 | Extraction, coronal remnants - deciduous tooth | \$0.00 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | \$0.00 |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | \$30.00 |
| D7220 | Removal of impacted tooth - soft tissue | \$45.00 |
| D7230 | Removal of impacted tooth - partially bony | \$65.00 |
| D7240 | Removal of impacted tooth - completely bony | \$80.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | \$100.00 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | \$35.00 |
| D7251 | Coronectomy – intentional partial tooth removal | \$100.00 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | \$50.00 |
| D7280 | Surgical access of an unerupted tooth | \$85.00 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | \$90.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | \$90.00 |
| D7285 | Incisional biopsy of oral tissue-hard (bone, tooth) - does not include pathology laboratory procedures | \$0.00 |
| D7286 | Incisional biopsy of oral tissue-soft - does not include pathology laboratory procedures | \$0.00 |
| D7287 | Exfoliative cytological sample collection | \$50.00 |
| D7288 | Brush biopsy - transepithelial sample collection | \$50.00 |
| D7310 | Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$35.00 |
| D7311 | Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$25.00 |
| D7320 | Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$70.00 |
| D7321 | Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$65.00 |
| D7471 | Removal of lateral exostosis - (maxilla or mandible) | \$80.00 |
| D7472 | Removal of torus palatinus | \$60.00 |
| D7473 | Removal of torus mandibularis | \$60.00 |
| D7485 | Surgical reduction of osseous tuberosity | \$60.00 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | \$25.00 |
| D7511 | Incision and drainage of abscess - intraoral soft tissue - complicated | \$30.00 |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | \$30.00 |
| D7521 | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | \$30.00 |
| D7910 | Suture of Recent Small Wounds up to 5cm | \$25.00 |

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| D7960 | Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure | \$40.00 |
| D7963 | Frenuloplasty | \$40.00 |
| D7970 | Excision hyperplastic tissue - per arch | \$55.00 |
| D7971 | Excision of pericoronal gingiva | \$35.00 |

D8000-D8999

XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$25.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months. Pre and post orthodontic records include:

Pre- and-post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$0.00

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| D0210 | Intraoral - complete series (including bitewings) |
| D0322 | Tomographic survey |
| D0330 | Panoramic radiographic image |
| D0340 | Cephalometric radiographic image |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally |
| D0351 | 3D photographic image |
| D0470 | Diagnostic casts |

The benefit for post-treatment records includes: \$0.00

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|-------|---|--------------|
| D0210 | Intraoral - complete series (including bitewings) | |
| D0470 | Diagnostic casts | |
| D8010 | Limited orthodontic treatment of the primary dentition | \$1,000.00 |
| D8020 | Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19 | \$1,000.00 |
| D8030 | Limited orthodontic treatment of the adolescent dentition - adolescent to age 19 | \$1,000.00 |
| D8040 | Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children | \$1,000.00 |
| D8050 | Interceptive orthodontic treatment of the primary dentition | 25% Discount |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | 25% Discount |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 | \$1,800.00 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 | \$1,800.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children | \$1,800.00 |
| D8210 | Removable appliance therapy | 25% Discount |

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| D8220 | Fixed appliance therapy | 25% Discount |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | \$0.00 |
| D8670 | Periodic orthodontic treatment visit | \$0.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of removable retainers) | \$300.00 |
| D8693 | Re-bond or re-cement fixed retainer | \$0.00 |
| D8694 | Repair of fixed retainers, includes reattachment - <i>limited to 2 per 6 month period</i> | \$0.00 |
| D8999 | Unspecified orthodontic procedure, by report - includes treatment planning session | \$250.00 |

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

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| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | \$10.00 |
| D9120 | Fixed partial denture sectioning | \$0.00 |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | \$0.00 |
| D9211 | Regional block anesthesia | \$0.00 |
| D9212 | Trigeminal division block anesthesia | \$0.00 |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | \$0.00 |
| D9219 | Evaluation for deep sedation or general anesthesia | \$0.00 |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | \$150.00 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | \$45.00 |
| D9230 | Inhalation of nitrous oxide/anxiolysis, analgesia | \$15.00 |
| D9241 | Intravenous moderate (conscious) sedation/analgesia - first 30 minutes | \$150.00 |
| D9242 | Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes | \$45.00 |
| D9248 | Non-intravenous moderate (conscious) sedation | \$15.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | \$0.00 |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | \$0.00 |
| D9440 | Office visit - after regularly scheduled hours | \$30.00 |
| D9450 | Case presentation, detailed and extensive treatment planning | \$0.00 |
| D9610 | Therapeutic parenteral drug, single administration | \$15.00 |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | \$25.00 |
| D9630 | Other drugs and/or medicaments, by report | \$15.00 |
| D9910 | Application of desensitizing medicament | \$15.00 |
| D9931 | Cleaning and inspection of a removable appliance | \$0.00 |
| D9940 | Occlusal guard, by report - <i>limited to 1 in 3 years</i> | \$85.00 |
| D9942 | Repair and/or reline of occlusal guard | \$40.00 |
| D9951 | Occlusal adjustment, limited | \$25.00 |
| D9952 | Occlusal adjustment, complete | \$100.00 |

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| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays | \$125.00 |
| D9986 | Missed appointment - <i>without 24 hour notice</i> | \$25.00 |
| D9987 | Canceled appointment - <i>without 24 hour notice</i> | \$25.00 |

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. During the course of treatment, your Contract Dentist may recommend the services of a dental specialist. Your Contract Dentist may refer you directly to a Contract Specialist; referral approval from Delta Dental is not required. However, certain procedures may require pre-treatment authorization prior to care. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 1.800.693.2589.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
2. Any procedures not specifically listed as a covered benefit in this Plan's Schedule A are available at 75% of the filed fees of the Enrollee's selected Contract Dentist or Contract Specialist, provided the services are included in the treatment plan and are not specifically excluded.
3. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the filed fees of the Enrollee's selected Contract Dentist or Contract Specialist, unless specifically listed as a covered benefit on Schedule A.
4. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$25.00 above the listed Copayment for each of these services after the sixth unit has been provided.
5. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
6. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of the Enrollee's selected Contract Dentist or Contract Specialist's filed fees.

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DeltaCare® USA (DHMO)

High Plan

7. Benefits provided by a pediatric Dentist are limited to children, through the end of the month that the dependent child turns age eight.
 8. The cost to an Enrollee receiving orthodontic treatment whose coverage is canceled or terminated for any reason will be based on the Contract Orthodontist's filed fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
 9. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
7. implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
 7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
 8. Consultations or other diagnostic services for non-covered benefits.
 9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist or Contract Orthodontist) except for Emergency Services as described in the Contract and/or Evidence of Coverage.
 10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
 11. Over-the-counter drugs; prescription drugs not administered by the Enrollee's selected Contract Dentist or Contract Specialist.
 12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
 13. Changes in orthodontic treatment necessitated by accident of any kind.
 14. Myofunctional and parafunctional appliances and/or therapies.
 15. Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
 16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
 17. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
 18. Dental services required while serving in the Armed Forces or any country or international authority.
 19. Dental services considered experimental in nature.
 20. Orthognathic surgery.
 21. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the Enrollee's dental health, as determined by the DeltaCare USA Contract Dentist.
 22. Treatment of malignancies, cysts, or neoplasms unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.

Exclusions of Benefits

1. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
2. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) with the exception of procedures D9951 and D9952 as shown on Schedule A.
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays,

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Delta Dental PPOSM



The Delta Dental Preferred Provider Organization (PPO) plans are preferred provider organization plans that allow you and your family to visit any dentist, but provide cost savings when you visit an in-network dentist. Delta Dental offers you a choice of two different plans.

The Standard Plan

The Standard Plan is a low-cost plan that is designed for those individuals who primarily would need only diagnostic and preventive dental services. The Standard Plan includes a copayment schedule that applies to the various dental procedures when you visit an in-network dentist. You do not have to satisfy an annual calendar year deductible if you seek services from an in-network PPO dentist. When you visit an out-of-network dentist, you are responsible for a percentage of the dentist's charges, which is referred to as "coinsurance."

The High Plan

The High Plan is designed for those individuals who have more extensive dental needs. This plan provides a reimbursement of either 100, 80 or 50% of the plan's PPO dentist fees, depending on the service provided, after you have satisfied the plan deductible. Delta Dental offers quality dental care at affordable prices with their PPO plan. You have access to a nationwide network of dentists who have agreed to contracted fees, which helps reduce your costs. You are free to choose an in-network or out-of-network dentist at the time you make your appointment. However, when using an out-of-network dentist, the level of coverage is reduced and your out-of-pocket expenses will increase.

How to select the Delta Dental PPO plan

Employee-Paid Benefits:

1. You may cover yourself by selecting the "Employee-only" benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.

NOTE: If you choose dependent dental coverage, your dependents must be covered by the same dental plan and level of coverage (Standard or High) which you selected for yourself.

About Delta Dental PPO

Pre-treatment estimate:

Ask your dentist to obtain a pre-treatment estimate from Delta Dental for any services that are expected to exceed \$300. This free service gives you an estimate of your costs for the service. This provision does not apply to charges for emergency treatment.

>> Benefit Eligibility Note:

- **All M-DCPS groups are eligible to enroll in the DeltaCare USA offered by the School Board.**
- **Current COBRA participants may only continue to enroll in DeltaCare USA if you were previously enrolled in vision.**
- **See eligibility section for more details.**



Delta Dental PPOSM

Where can I get claim forms?

Dental claim forms will be provided to you upon request at the Office of Risk and Benefits Management. For claims assistance or status, log on to www.deltadentalins.com/mdcps or call Delta Dental Customer Service at 1.800.693.2589.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to Delta Dental Customer Service at 1.800.693.2589.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/domestic partner
- Unmarried natural children, adopted children, and stepchildren to the end of the calendar year they reach age 26
- Children older than age 26 will remain covered under this plan only if proof is submitted that they suffer from a physical handicap or mental retardation, provided they remain chiefly dependent upon you for support.
- Children of a domestic partner, as long as the domestic partner is also covered.

This example indicates your savings using the Delta Dental PPO High Dental Plan (Filling-Type B service):

In-Network (PPO)

| | |
|--------------------------|-----------------|
| PPO Dentist Fee | \$ 62.60 |
| Plan pays 80% of PPO Fee | - \$ 50.08 |
| You pay 20% of PPO Fee | \$12.52 |
| Your cost | \$12.52* |

Out-of-Network

| | |
|------------------------------|-------------------|
| Dentist Fee | \$190.00 |
| PPO Fee | \$62.60 |
| Plan pays 80% of PPO Fee | - \$50.08 |
| You pay 20% of PPO Fee | \$12.52 |
| Plus Charge over Dentist Fee | \$127.40 |
| Your cost | \$139.92** |

Total \$\$\$ saved by using a Delta Dental PPO dentist = \$127.40

* Example assumes \$50 deductible has been satisfied.

**Example assumes \$150 deductible has been satisfied.



Delta Dental PPOSM

Standard Plan

| STANDARD PLAN BENEFITS | PPO Network | Non - PPO Network** |
|---|----------------------|--|
| ANNUAL CALENDAR YEAR DEDUCTIBLE | | |
| Deductible applies to: | None | \$50/person \$150/ family (type A,B,C) |
| ANNUAL CALENDAR YEAR MAXIMUM | | |
| Maximum benefit allowed per person for Types A, B & C Combined | \$1,500 | \$1,500 |
| PREVENTIVE (Type A) | Employee Pays | Plan Pays |
| X-rays (bitewing 2 per year) | \$0 | 90% ** |
| X-rays (full mouth or panoramic every 3 years) | \$0 | 90% ** |
| Cleaning and scaling (2 per year) | \$15 | 90% ** |
| Fluoride treatment (up to age 19 - two per year) | \$0 | 90% ** |
| BASIC SERVICE (Type B) | | |
| Space Maintainers - unilateral (up to age 19) | \$105 | 60% ** |
| Sealants (Dependent child up to age 19 - once every 2 years on permanent molars only) | \$15 | 60% ** |
| Amalgams (2 surfaces) | \$45 | 60% ** |
| Periodontics maintenance (4 per calendar year less regular cleanings) | \$40 | 60% ** |
| MAJOR SERVICE (Type C) | | |
| Denture relining (chairside) | \$105 | 30% ** |
| Denture adjustments | \$30 | 30% ** |
| General anesthesia (30 minutes) | \$155 | 30% ** |
| Impacted Teeth | \$145 | 30% ** |
| Periodontics (gum treatment) scaling and root planing | \$85 per quad | 30% ** |
| Crowns | \$475 | 30% ** |
| Bridges | \$435 | 30% ** |
| Full dentures | \$535 | 30% ** |
| Partial dentures | \$420 | 30% ** |
| Resin base Inlays | \$330 | 30% ** |
| Onlays | \$475 | 30% ** |
| Simple extractions | \$50 | 30% ** |
| Additional extraction | \$50 | 30% ** |
| Surgical extractions | \$105 | 30% ** |
| ORTHODONTIA (Type D) | | |
| Amount | \$2,100 | 50% ** \$1500/person |

** Non - PPO Network: Member pays balance in addition to the remaining balance of claim. Balance equals the difference between total claim and PPO fee.

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Delta Dental PPOSM

Standard Plan

Diagnostic and Preventive Benefits and Limitations:

- Oral exams but not more than twice in a calendar year
- Full mouth or panoramic x-rays but not more than once every 36 months
- Bitewing x-rays but not more than twice per calendar year
- Cleaning of teeth (oral prophylaxis) but not more than twice in a calendar year
- Topical fluoride treatment twice in a calendar year for a dependent child 19 years of age or younger

Basic Benefits and Limitations:

- Intraoral-periapical x-rays and other x-rays not specified under Diagnostic and Preventive Benefits
- Pulp vitality tests
- Diagnostic casts
- Bacteriological studies for determinations of pathological agents
- Initial placement of amalgam or composite fillings
- Replacement of an existing amalgam or composite fillings
- Sedative fillings
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Periodontal maintenance where periodontal treatment (including scaling, root planning and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four (4) times per calendar year less the number of teeth cleanings received during such calendar year.
- Emergency palliative treatment to relieve tooth pain
- For dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 24 months
- For dependent children 19 years of age or younger, space maintainers

Major Benefits and Limitations:

- Prefabricated stainless steel crown or prefabricated resin crown, but not more than one per tooth within two (2) years
- Repair or re-cementing of Cast Restorations (Cast Restoration means an inlay, onlay or crown.)

- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period
- Periodontal scaling and root planing but not more than once per quadrant in any 24 month period
- Initial installation of Cast Restorations
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within five (5) years
- Oral surgery except as mentioned elsewhere
- Pulp therapy and apexification/recalcification
- Extractions of unimpacted teeth and removal of exposed roots
- Extractions of impacted teeth
- Root canal treatment but not more than once in a 24 month period for same tooth
- Initial installation of full or removable Dentures (Denture means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.)
- Addition of teeth to a partial removable Denture to replace natural teeth removed while covered dental services are in effect for the Enrollee receiving such services
- Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to replacement
- Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture
- Repair of Dentures
- Relinings and rebasings of existing removable Dentures if at least six (6) months have passed since the installation of the existing removable Denture and not more than once in any 36 month period
- Other removable prosthetic services not described elsewhere
- Other fixed Denture prosthetic services not described elsewhere
- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of five (5) years
- Adjustments of Dentures, if at least six (6) months have passed since the installation of the Denture
- Administration of general anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures



Delta Dental PPOSM

Standard Plan

- Consultations, but not more than twice in a calendar year
- Injections of therapeutic drugs
- Local chemotherapeutic agents
- Fixed removable appliances for correction of harmful habits

Orthodontic Benefits and Limitations:

- Orthodontic Services mean procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of misalignment of teeth and/or jaws which significantly interferes with their functions
- Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility
- Benefits are not paid to repair or replace any orthodontic appliance received under this program
- Benefits are not provided for orthodontic retreatment procedures

Note on additional benefits during pregnancy - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each calendar year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Exclusions

- Treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law
- Cosmetic surgery or dentistry for purely cosmetic reasons
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity
- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment

- Any Single Procedure started prior to the date the Enrollee became covered for such services under this program
- Prescribed drugs, medication, pain killers or experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues)
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments
- Services or supplies covered by any other health plan of the Contract holder
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption
- Services for any disturbances of the temporomandibular (jaw) joints
- Replacement of a lost, missing or stolen crown, bridge or denture
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Temporary or provisional restoration
- Temporary or provisional appliance
- Adjustment of a denture or a bridgework which is made within six (6) months after installation by the same Dentist who installed it
- Any duplicate appliance or prosthetic device
- Charges made by a Dentist for failure to keep a scheduled visit with such Dentist
- Sterilization supplies
- Implantology
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards

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Delta Dental PPOSM

High Plan

| HIGH PLAN BENEFITS | PPO Network | Non - PPO Network** |
|---|---|---|
| ANNUAL CALENDAR YEAR DEDUCTIBLE | | |
| Deductible applies to: | \$50/ person \$150/ family (type B,C) | \$50/ person \$150/ family (type A, B, C) |
| ANNUAL CALENDAR YEAR MAXIMUM | | |
| Maximum benefit allowed per person for Types A, B & C Combined | \$1,500 | \$1,500 |
| PREVENTIVE (Type A) | | |
| | Plan Pays | Plan Pays |
| X-rays (bitewing 2 per year) | 100% | 100% ** |
| X-rays (full mouth or panoramic every 3 years) | 100% | 100% ** |
| Cleaning and scaling (2 per year) | 100% | 100% ** |
| Fluoride treatment (up to age 19 - two per year) | 100% | 100% ** |
| Space maintainers - unilateral (up to age 19) | 100% | 100% ** |
| Sealants (Dependent child up to age 19 - once every 2 years on permanent molars only) | 100% | 100% ** |
| BASIC SERVICE (Type B) | | |
| Amalgams (2 surfaces) | 80%* | 80% ** |
| Periodontics maintenance (4 per calendar year less regular cleanings) | 80%* | 80% ** |
| MAJOR SERVICE (Type C) | | |
| Denture relining (chairside) | 50% * | 50% ** |
| Denture adjustments | 50% * | 50% ** |
| General anesthesia (30 minutes) | 50% * | 50% ** |
| Impacted teeth | 50% * | 50% ** |
| Periodontics (gum treatment) scaling and root planing | 50% * | 50% ** |
| Crowns | 50% * | 50% ** |
| Bridges | 50% * | 50% ** |
| Full dentures | 50% * | 50% ** |
| Partial dentures | 50% * | 50% ** |
| Resin base Inlays | 50% * | 50% ** |
| Onlays | 50% * | 50% ** |
| Simple extractions | 50% * | 50% ** |
| Additional extraction | 50% * | 50% ** |
| Surgical extractions | 50% * | 50% ** |
| Root canal therapy Anterior | 50% * | 50% ** |
| Bicuspid | 50% * | 50% ** |
| Molar | 50% * | 50% ** |
| Repairs to prosthetics | 50% * | 50% ** |
| ORTHODONTIA (Type D) | | |
| Amount | 50%* \$1500/person | 50% ** \$1500/person |

* PPO Network: Member pays balance after plan pays.

** Non - PPO Network: Member pays balance in addition to the remaining balance of claim. Balance equals the difference between total claim and PPO fee.

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Delta Dental PPOSM

High Plan

Diagnostic and Preventive Benefits and Limitations:

- Oral exams but not more than twice in a calendar year
- Full mouth or panoramic x-rays but not more than once every 36 months
- Bitewing x-rays but not more than twice per calendar year
- Cleaning of teeth (oral prophylaxis) but not more than twice in a calendar year
- Topical fluoride treatment twice in a calendar year for a dependent child 19 years of age or younger
- For dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 24 months
- For dependent children 19 years of age or younger, space maintainers

Basic Benefits and Limitations:

- Intraoral-periapical x-rays and other x-rays not specified under Diagnostic and Preventive Benefits
- Pulp vitality tests
- Diagnostic casts
- Bacteriological studies for determinations of pathological agents
- Initial placement of amalgam or composite fillings
- Replacement of an existing amalgam or composite fillings
- Sedative fillings
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Periodontal maintenance where periodontal treatment (including scaling, root planing and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four (4) times per calendar year less the number of teeth cleanings received during such calendar year.
- Emergency palliative treatment to relieve tooth pain

Major Benefits and Limitations:

- Prefabricated stainless steel crown or prefabricated resin crown, but not more than one per tooth within two (2) years
- Repair or re-cementing of Cast Restorations (Cast Restoration means an inlay, onlay or crown.)
- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period

- Periodontal scaling and root planing but not more than once per quadrant in any 24 month period
- Initial installation of Cast Restorations
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within five (5) years
- Oral surgery except as mentioned elsewhere
- Pulp therapy and apexification/recalcification
- Extractions of unimpacted teeth and removal of exposed roots
- Extractions of impacted teeth
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- Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to replacement
- Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture
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- Other fixed Denture prosthetic services not described elsewhere
- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of five (5) years
- Adjustments of Dentures, if at least six (6) months have passed since the installation of the Denture
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- Consultations, but not more than twice in a calendar year
- Injections of therapeutic drugs
- Local chemotherapeutic agents
- Fixed removable appliances for correction of harmful habits

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Delta Dental PPOSM

High Plan

Orthodontic Benefits and Limitations:

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Exclusions

- Treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law
- Cosmetic surgery or dentistry for purely cosmetic reasons
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity
- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment
- Any Single Procedure started prior to the date the Enrollee became covered for such services under this program
- Prescribed drugs, medication, pain killers or experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues)
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments
- Services or supplies covered by any other health plan of the Contract holder
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption
- Services for any disturbances of the temporomandibular (jaw) joints
- Replacement of a lost, missing or stolen crown, bridge or denture
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Temporary or provisional restoration
- Temporary or provisional appliance
- Adjustment of a denture or a bridgework which is made within six (6) months after installation by the same Dentist who installed it
- Any duplicate appliance or prosthetic device
- Charges made by a Dentist for failure to keep a scheduled visit with such Dentist
- Sterilization supplies
- Implantology
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards

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