Pediatric Dental
Evidence of Coverage

(TO BE ADDED TO WHA EOC)

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INTRODUCTION

This document is an addendum to your WHA *Evidence of Coverage* ("WHA EOC") to add coverage for pediatric dental services as described in this dental *Evidence of Coverage and Disclosure Form* ("Dental EOC" or "Addendum").

WHA contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare USA network of Contract Dentists available to you. You can obtain covered Benefits from your assigned Contract Dentist without a referral from a Plan Physician. Your Cost Share is due when you receive covered Benefits. These pediatric dental Benefits are for children from birth to age 19 who meet the eligibility requirements specified in your WHA EOC.

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Contract Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. To fully understand your coverage, you may wish to carefully review this Dental EOC.

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Service Center at **800-471-9925**, from 5 a.m. – 6 p.m. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by your Health Plan.

Using This Dental EOC

This Addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how this dental plan works and how to obtain dental care. Please read this Dental EOC completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Health Care Needs." A matrix ("Schedule C") describing this Plan's major Benefits and coverage can be found on the last page of this Dental EOC.

DEFINITIONS

In addition to the terms defined in the "Definitions" section of your WHA EOC, the following terms, when capitalized and used in any part of this Dental EOC, have the following meanings:

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described throughout this Addendum may be performed by the Administrator as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to **800-471-9925**.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit to Enrollees under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of this Addendum.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits under this dental plan.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits under this dental plan which covers medically necessary orthodontics.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this dental plan.

Copayment: see definition of “Cost Share.”

Cost Share: the amount listed in the Schedules attached to this Addendum and charged to an Eligible Pediatric Individual by a Contract Dentist or Contract Specialist for the Benefits provided under this Plan. Cost Share amounts must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

Dentist: a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Eligible Pediatric Individual: a person who is eligible to enroll for Pediatric Benefits as described in this Addendum.

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part, or
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Enrollee: an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under this dental plan.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this Addendum.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of this Addendum.

Procedure Code: the Current Dental Terminology® ("CDT") number assigned to a Single Procedure by the American Dental Association.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to their assigned Contract Dentist facility because of a physical disability, and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Contract Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Renewal and Termination of Coverage

Please refer to your WHA EOC for further information regarding renewal and termination of this Plan.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Contract Dentists are screened to ensure that our standards of quality, access and safety are maintained. The DeltaCare USA network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Cost Share for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

The DeltaCare USA Plan provides the Benefits described in the Schedules that are a part of this Dental EOC. Benefits are only available in the state of California. Services are performed as deemed appropriate by your assigned Contract Dentist.

Cost Share and Other Charges

You are required to pay any Cost Share listed in the Schedules attached to this Dental EOC. Your Cost Share is paid directly to the Contract Dentist who provides treatment.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA dentist contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in the "Emergency Dental Services" of this Dental EOC, if you have not received prior Authorization for treatment from an Out-of-Network Dentist and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the "Emergency Dental Services" and "Specialist Services" sections in this Dental EOC.

HOW TO USE THE DELTACARE USA PLAN / CHOICE OF CONTRACT DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIST SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

Delta Dental will provide Enrollees with Contract Dentists at convenient locations during the term of this Dental EOC. Upon enrollment, Delta Dental will assign Enrollees covered under this Dental EOC to one Contract Dentist facility. The Enrollee may request changes to the assigned Contract Dentist facility by contacting our Customer Service Center at **800-471-9925**. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

The Enrollee will be provided with written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from this dental plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits must be performed at the Enrollee's assigned Contract Dentist facility. With the exception of Emergency Dental Services and authorized Specialist Services, this dental plan does not pay for

services received by Out-of-Network Dentists. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Cost Share. Any other treatment is not covered under this Plan.

A Contract Dentist may provide services either personally or through associated Dentists or technicians or hygienists who may lawfully perform the services. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

If your assigned Contract Dentist facility terminates participation in this dental plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, your Contract Dentist is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental will give you reasonable advance written notice if you will be materially or adversely affected by the termination, breach of contract or inability of a Contract Dentist to perform services.

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Dental EOC with your terminated Contract Dentist for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Dental EOC with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact our Customer Service Center at **800-471-9925**. You may also contact us to request a copy of Delta Dental's *Continuity of Care Policy*. Delta Dental is not required to continue care with the Dentist if you are not eligible under this dental plan or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. The Enrollee's assigned Contract Dentist facility maintains a 24 hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, the Enrollee can call 911 (where available) or obtain Emergency Dental Services from any dental provider without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist facility.

The Enrollee is responsible for any Cost Share for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this dental plan.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, this dental plan covers medically necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Enrollee receives Urgent Dental Services from an Out-of-Network Dentist while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered by this dental plan if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

This dental plan does not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their assigned Contract Dentist.

The Enrollee is responsible for any Cost Share for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if the Enrollee is calling due to an Emergency Dental Condition.

If the Enrollee calls Delta Dental's Customer Service Center, a representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists or Contract Specialists' facilities, the Enrollee may call our Customer Service Center at **800-471-9925** for assistance.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by your assigned Contract Dentist, and 2) authorized by Delta Dental. You pay the specified Cost Share. (Refer to the Schedules attached to this Dental EOC.)

If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered by this dental plan.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Dental EOC to determine Benefits available to you under this dental plan.

Claims for Reimbursement

Claims for covered Emergency Dental Services and authorized Specialist Services should be sent to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All dental claims must be received within (1) year of the treatment date. The address for claims submission is: Delta Dental, Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist) and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at the toll-free telephone number shown in this Dental EOC.

Processing Policies

The dental care guidelines for this DeltaCare USA Plan explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of this dental plan are provided subject to any Cost Share. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Delta Dental's Customer Service Center at **800-471-9925** for information regarding the dental care guidelines for this dental plan.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner appropriate to the nature of the Enrollee's condition. Requests involving an Emergency Dental Condition will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, contact Delta Dental's Customer Service at **800-471-9925** or write to Delta Dental.

Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network Dentist if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance with us or with the Department. Refer to the "Enrollee Complaint Procedure" section in this Dental EOC for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service Center at **800-471-9925**. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits.

Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service Center at **800-471-9925**.

Enrollee Complaint Procedure

Complaints regarding dental services:

Delta Dental or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have a complaint regarding the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator or the quality of dental services performed by a Contract Dentist, you may call Delta Dental's Customer Service Center at **800-471-9925** or the complaint may be addressed in writing to:

Delta Dental of California
Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the Enrollee's name, address, telephone number and ID number and 2) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding Delta Dental and/or your dental provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by Enrollee or the Enrollee's representative. Where Delta Dental is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within five calendar days of the receipt of any complaint, a quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 calendar days of receipt of a complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the Department. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone Delta Dental at **800-471-9925** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, a grievance that has not been satisfactorily resolved by us, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), you may contact the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") for further review of

the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Complaints involving an adverse determination on dental services:

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), the Enrollee must file a request for review (a complaint) with Delta Dental within 180 calendar days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within five calendar days of the receipt of any complaint, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint which will include the date of receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 calendar days of receipt of your complaint.

Independent Medical Review ("IMR")

An enrollee of a health care service plan in California has the right to request an IMR from the Department after completing their health/dental plan's grievance process. The IMR, by nature, is specific to medical plans; however, an IMR is applicable to dental plans only when it is a packaged offering with a medical plan issuer. To determine eligibility, you may contact the Department **1-888-HMO-2219** or **1-877-688-9891** (TDD) for assistance or visit their website at http://www.hmohelp.ca.gov.

GENERAL PROVISIONS

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental EOC. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Delta Dental's Customer Service Center at **800-471-0287**.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance electronically online, over the phone with a Customer Service representative or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 1-800-471-0287
Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SCHEDULE A

Description of Benefits and Cost Shares for Pediatric Benefits (Under Age 19)

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). 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 this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2018 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA 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.

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D0100–D0999 I. DIAGNOSTIC			
- Benefits in this category are not subject to the Plan Deductible described in your <EOC NAME>.			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Enrollee per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 per 3 months, not to exceed 12 per 12 month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D0210	Intraoral - complete series of radiographic images	No charge	*1 series every 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 (D0272 D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 (D0270, D0273) per date of service; 1 (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0351	3D photographic image	No charge	*1 per date of service*
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 36 months per Contract Dentist or dental office*
D1000-D1999 II. PREVENTIVE			
- Benefits in this category are not subject to the Plan Deductible described in your <EOC NAME>.			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Dentist or dental office is responsible for any repair or replacement during the 36-month period.*
D1354	Interim caries arresting medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed - unilateral	No charge	*1 per quadrant; posterior teeth*
D1515	Space maintainer - fixed - bilateral	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable - unilateral	No charge	*1 per quadrant; posterior teeth*
D1525	Space maintainer - removable - bilateral	No charge	*1 per arch, through age 17; posterior teeth*
D1550	Re-cement or re-bond space maintainer	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1555	Removal of fixed space maintainer	No charge	*Included in case by Contract Dentist or dental office who placed appliance*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D1575	Distal shoe space maintainer - fixed - unilateral	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D2140	Amalgam - one surface, primary or permanent	$66	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$80	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$100	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$109	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$87	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$87	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$94	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$118	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$204	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$85	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$117	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$142	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
			months per Contract Dentist for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior	$155	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$269	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$269	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$646	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic	$646	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$630	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$591	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$591	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$630	*1 per 60 months, permanent teeth; age 13 through 18*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$57	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$57	
D2920	Re-cement or re-bond crown	$56	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$89	*1 per 12 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$181	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$116	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$129	*1 per 36 months*
D2932	Prefabricated resin crown	$125	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$181	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$40	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration – primary dentition	$40	*1 per tooth per 6 months, per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$196	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D2950	Core buildup, including any pins when required	$95	
D2951	Pin retention - per tooth, in addition to restoration	$33	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$172	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$104	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$136	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$226	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$109	*Performed in conjunction with D2954*
D2971	Additional procedures to construct new crown under existing partial denture framework	$65	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$223	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*
D2999	Unspecified restorative procedure, by report	$218	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D3110	Pulp cap - direct (excluding final restoration)	$47	
D3120	Pulp cap - indirect (excluding final restoration)	$36	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$66	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$56	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$66	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$66	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$66	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$365	*Root canal*
D3320	Endodontic therapy, premolar (excluding final restoration)	$438	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$586	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$153	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$391	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - premolar	$469	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$629	*Retreatment during the 12 months following initial treatment is*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
			included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$80	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$80	*1 per permanent tooth*
D3410	Apicoectomy - anterior	$276	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$305	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$317	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$103	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a Benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3427	Periradicular surgery without apicoectomy	$95	*1 per 24 months by the same Contract Dentist or dental office*
D3430	Retrograde filling - per root	$95	
D3910	Surgical procedure for isolation of tooth with rubber dam	$36	
D3999	Unspecified endodontic procedure, by report	$192	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$234	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4249	Clinical crown lengthening - hard tissue	$240	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$399	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$240	*1 per quadrant per 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$320	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$114	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$69	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$64	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$64	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$24	
D4910	Periodontal maintenance	$89	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$53	*1 per Contract Dentist; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D4999	Unspecified periodontal procedure, by report	$120	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Cost Share 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.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D5110	Complete denture - maxillary	$857	*1 per 60 months*
D5120	Complete denture - mandibular	$857	*1 per 60 months*
D5130	Immediate denture - maxillary	$943	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$943	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$777	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$827	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,037	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,037	*1 per 60 months*
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$813	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$833	*1 per 60 months*
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,212	*1 per 60 months*
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,222	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$43	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$43	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$44	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$44	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$106	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$106	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$73	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$92	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$92	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$143	*1 per arch, per day of service per Contract Dentist; up to 2 per arch*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
			per 12 months per Contract Dentist after the initial 6 months
D5622	Repair cast partial framework, maxillary	$143	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken clasp - per tooth	$141	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist.*
D5640	Replace broken teeth - per tooth	$93	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$118	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$141	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (chairside)	$152	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (chairside)	$152	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (chairside)	$148	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (chairside)	$148	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (laboratory)	$261	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (laboratory)	$261	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (laboratory)	$241	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (laboratory)	$241	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$74	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$74	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$239	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture – complete maxillary	$857	*1 per 60 months*
D5864	Overdenture – partial maxillary	$1,037	*1 per 60 months*
D5865	Overdenture – complete mandibular	$857	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5866	Overdenture – partial mandibular	$1,037	*1 per 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$339	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D5911	Facial moulage (sectional)	$150	
D5912	Facial moulage (complete)	$228	
D5913	Nasal prosthesis	$3,798	
D5914	Auricular prosthesis	$3,798	
D5915	Orbital prosthesis	$5,127	
D5916	Ocular prosthesis	$5,317	
D5919	Facial prosthesis	$823	
D5922	Nasal septal prosthesis	$2,281	
D5923	Ocular prosthesis, interim	$3,039	
D5924	Cranial prosthesis	$249	
D5925	Facial augmentation implant prosthesis	$1,070	
D5926	Nasal prosthesis, replacement	$545	
D5927	Auricular prosthesis, replacement	$1,899	
D5928	Orbital prosthesis, replacement	$450	
D5929	Facial prosthesis, replacement	$507	
D5931	Obturator prosthesis, surgical	$1,056	
D5932	Obturator prosthesis, definitive	$1,200	
D5933	Obturator prosthesis, modification	$338	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$2,848	
D5935	Mandibular resection prosthesis without guide flange	$2,848	
D5936	Obturator prosthesis, interim	$610	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5937	Trismus appliance (not for TMD treatment)	$328	
D5951	Feeding aid	$195	
D5952	Speech aid prosthesis, pediatric	$500	
D5953	Speech aid prosthesis, adult	$873	
D5954	Palatal augmentation prosthesis	$184	
D5955	Palatal lift prosthesis, definitive	$2,469	
D5958	Palatal lift prosthesis, interim	$1,443	
D5959	Palatal lift prosthesis, modification	$456	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$304	*2 per 12 months*
D5982	Surgical stent	$300	
D5983	Radiation carrier	$487	
D5984	Radiation shield	$274	
D5985	Radiation cone locator	$1,063	
D5986	Fluoride gel carrier	$166	
D5987	Commissure splint	$302	
D5988	Surgical splint	$297	
D5991	Vesiculobullous disease medicament carrier	$242	
D5999	Unspecified maxillofacial prosthesis, by report	$389	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D6010	Surgical placement of implant body: endosteal implant	$1,281	*A Benefit only under exceptional medical conditions.*
D6011	Second stage implant surgery	$485	*A Benefit only under exceptional medical conditions.*
D6013	Surgical placement of mini implant	$641	*A Benefit only under exceptional medical conditions.*
D6040	Surgical placement: eposteal implant	$1,601	*A Benefit only under exceptional medical conditions.*
D6050	Surgical placement: transosteal implant	$1,554	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6052	Semi-precision attachment abutment	$641	*A Benefit only under exceptional medical conditions.*
D6055	Connecting bar – implant supported or abutment supported	$1,428	*A Benefit only under exceptional medical conditions.*
D6056	Prefabricated abutment – includes modification and placement	$448	*A Benefit only under exceptional medical conditions.*
D6057	Custom fabricated abutment – includes placement	$560	*A Benefit only under exceptional medical conditions.*
D6058	Abutment supported porcelain/ceramic crown	$860	*A Benefit only under exceptional medical conditions.*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$782	*A Benefit only under exceptional medical conditions.*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$755	*A Benefit only under exceptional medical conditions.*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$773	*A Benefit only under exceptional medical conditions.*
D6062	Abutment supported cast metal crown (high noble metal)	$782	*A Benefit only under exceptional medical conditions.*
D6063	Abutment supported cast metal crown (predominantly base metal)	$756	*A Benefit only under exceptional medical conditions.*
D6064	Abutment supported cast metal crown (noble metal)	$773	*A Benefit only under exceptional medical conditions.*
D6065	Implant supported porcelain/ceramic crown	$1,024	*A Benefit only under exceptional medical conditions.*
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$984	*A Benefit only under exceptional medical conditions.*
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$976	*A Benefit only under exceptional medical conditions.*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$1,089	*A Benefit only under exceptional medical conditions.*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$1,121	*A Benefit only under exceptional medical conditions.*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$673	*A Benefit only under exceptional medical conditions.*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$944	*A Benefit only under exceptional medical conditions.*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$897	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$881	*A Benefit only under exceptional medical conditions.*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$894	*A Benefit only under exceptional medical conditions.*
D6075	Implant supported retainer for ceramic FPD	$907	*A Benefit only under exceptional medical conditions.*
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$1,377	*A Benefit only under exceptional medical conditions.*
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$944	*A Benefit only under exceptional medical conditions.*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$128	*A Benefit only under exceptional medical conditions.*
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$86	*A Benefit only under exceptional medical conditions.*
D6085	Provisional implant crown	$288	*A Benefit only under exceptional medical conditions.*
D6090	Repair implant supported prosthesis, by report	$234	*A Benefit only under exceptional medical conditions.*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$223	*A Benefit only under exceptional medical conditions.*
D6092	Re-cement or re-bond implant/abutment supported crown	$56	*A Benefit only under exceptional medical conditions.*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$67	*A Benefit only under exceptional medical conditions.*
D6094	Abutment supported crown - (titanium)	$851	*A Benefit only under exceptional medical conditions.*
D6095	Repair implant abutment, by report	$300	*A Benefit only under exceptional medical conditions.*
D6096	Remove broken implant retaining screw	$56	*A Benefit only under exceptional medical conditions*
D6100	Implant removal, by report	$354	*A Benefit only under exceptional medical conditions.*
D6110	Implant /abutment supported removable	$1,648	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
	denture for edentulous arch – maxillary		
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	$1,648	*A Benefit only under exceptional medical conditions.*
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	$961	*A Benefit only under exceptional medical conditions.*
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	$961	*A Benefit only under exceptional medical conditions.*
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	$1,473	*A Benefit only under exceptional medical conditions.*
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	$1,473	*A Benefit only under exceptional medical conditions.*
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$1,281	*A Benefit only under exceptional medical conditions.*
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$1,281	*A Benefit only under exceptional medical conditions.*
D6190	Radiographic/surgical implant index, by report	$343	*A Benefit only under exceptional medical conditions.*
D6194	Abutment supported retainer crown for FPD (titanium)	$897	*A Benefit only under exceptional medical conditions.*
D6199	Unspecified implant procedure, by report	$370	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D6211	Pontic - cast predominantly base metal	$547	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$579	*1 per 60 months; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6245	Pontic - porcelain/ceramic	$717	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$579	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$646	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$717	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$629	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$591	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$717	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$630	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$67	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$332	
D6999	Unspecified fixed prosthodontic procedure, by report	$289	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D7111	Extraction, coronal remnants - primary tooth	$37	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$74	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$109	
D7220	Removal of impacted tooth - soft tissue	$135	
D7230	Removal of impacted tooth - partially bony	$179	
D7240	Removal of impacted tooth - completely bony	$267	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$294	
D7250	Removal of residual tooth roots (cutting procedure)	$152	
D7260	Oroantral fistula closure	$154	
D7261	Primary closure of a sinus perforation	$154	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$224	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$103	
D7283	Placement of device to facilitate eruption of impacted tooth	$101	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue -hard (bone, tooth)	$93	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue -soft	$103	*3 per date of service*
D7290	Surgical repositioning of teeth	$109	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$104	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$106	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$64	
D7320	Alveoloplasty not in conjunction with extractions	$144	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
	- four or more teeth or tooth spaces, per quadrant		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$86	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$140	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$178	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$122	
D7411	Excision of benign lesion greater than 1.25 cm	$183	
D7412	Excision of benign lesion, complicated	$409	
D7413	Excision of malignant lesion up to 1.25 cm	$348	
D7414	Excision of malignant lesion greater than 1.25 cm	$263	
D7415	Excision of malignant lesion, complicated	$539	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$118	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$608	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$96	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$171	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$113	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$171	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$129	
D7471	Removal of lateral exostosis (maxilla or mandible)	$207	*1 per quadrant*
D7472	Removal of torus palatinus	$207	*1 per lifetime*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7473	Removal of torus mandibularis	$207	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$207	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$853	
D7510	Incision and drainage of abscess - intraoral soft tissue	$64	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$74	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$77	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$519	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$92	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$129	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$113	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$204	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$431	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$369	
D7630	Mandible - open reduction (teeth immobilized, if present)	$565	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$432	
D7650	Malar and/or zygomatic arch - open reduction	$750	
D7660	Malar and/or zygomatic arch - closed reduction	$239	
D7670	Alveolus - closed reduction may include stabilization of teeth	$225	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7671	Alveolus - open reduction may include stabilization of teeth	$456	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$897	
D7710	Maxilla - open reduction	$615	
D7720	Maxilla - closed reduction	$490	
D7730	Mandible - open reduction	$554	
D7740	Mandible - closed reduction	$491	
D7750	Malar and/or zygomatic arch - open reduction	$1,028	
D7760	Malar and/or zygomatic arch - closed reduction	$2,279	
D7770	Alveolus - open reduction stabilization of teeth	$99	
D7771	Alveolus, closed reduction stabilization of teeth	$776	
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$2,621	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$87	
D7830	Manipulation under anesthesia	$131	
D7840	Condylectomy	$3,168	
D7850	Surgical discectomy, with/without implant	$215	
D7852	Disc repair	$3,722	
D7854	Synovectomy	$3,798	
D7856	Myotomy	$1,861	
D7858	Joint reconstruction	$4,254	
D7860	Arthrotomy	$1,140	
D7865	Arthroplasty	$3,190	
D7870	Arthrocentesis	$152	
D7871	Non-arthroscopic lysis and lavage	$877	
D7872	Arthroscopy - diagnosis, with or without biopsy	$987	
D7873	Arthroscopy: lavage and lysis of adhesions	$1,083	
D7874	Arthroscopy: disc repositioning and stabilization	$2,893	
D7875	Arthroscopy: synovectomy	$1,462	
D7876	Arthroscopy: discectomy	$1,519	
D7877	Arthroscopy: debridement	$450	
D7880	Occlusal orthotic device, by report	$345	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7881	Occlusal orthotic device adjustment	$46	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$200	
D7910	Suture of recent small wounds up to 5 cm	$55	
D7911	Complicated suture - up to 5 cm	$199	
D7912	Complicated suture - greater than 5 cm	$287	
D7920	Skin graft (identify defect covered, location and type of graft)	$1,050	
D7940	Osteoplasty - for orthognathic deformities	$909	
D7941	Osteotomy - mandibular rami	$5,087	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$780	
D7944	Osteotomy - segmented or subapical	$1,169	
D7945	Osteotomy - body of mandible	$1,344	
D7946	Lefort I (maxilla - total)	$2,000	
D7947	Lefort I (maxilla - segmented)	$5,863	
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$2,200	
D7949	Lefort II or lefort III - with bone graft	$876	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$1,563	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$918	
D7952	Sinus augmentation via a vertical approach	$918	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$1,028	
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$109	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$274	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$152	*1 per arch per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7971	Excision of pericoronal gingiva	$103	
D7972	Surgical reduction of fibrous tuberosity	$103	*1 per quadrant per date of service*
D7979	Non - surgical sialolithotomy	$121	
D7980	Surgical sialolithotomy	$121	
D7981	Excision of salivary gland, by report	$406	
D7982	Sialodochoplasty	$77	
D7983	Closure of salivary fistula	$113	
D7990	Emergency tracheotomy	$121	
D7991	Coronoidectomy	$420	
D7995	Synthetic graft - mandible or facial bones, by report	$178	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$203	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$111	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Refer to Schedule B for additional information on medically necessary orthodontics			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
- Cost Share for medically necessary orthodontics applies to course of treatment, not individual Benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in the [Program/plan].			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$3,768	*1 per Enrollee per phase of treatment*
D8210	Removable appliance therapy	$452	*1 per lifetime; age 6 through 12*
D8220	Fixed appliance therapy	$543	*1 per lifetime; age 6 through 12*
D8660	Pre-orthodontic treatment examination to monitor growth and development	$137	*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*
D8670	Periodic orthodontic treatment visit	No charge	*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No charge	*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment	$46	
D8691	Repair of orthodontic appliance	No charge	*1 per appliance; included in comprehensive case fee*
D8692	Replacement of lost or broken retainer	$194	*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*
D8693	Re-cement or re-bond fixed retainer	No charge	*1 per Contract Dentist; included in comprehensive case fee*
D8694	Repair of fixed retainers, includes reattachment	No charge	*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D8999	Unspecified orthodontic procedure, by report	$561	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No charge	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$65	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$27	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$22	
D9212	Trigeminal division block anesthesia	$25	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$22	
D9222	Deep sedation/general anesthesia - first 15 minutes	$90	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$90	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	$35	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	$100	Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$100	*Covered only when given by a Contract Dentist for covered oral surgery*; 4 of (D9239, D9243) per date of service
D9248	Non-intravenous conscious sedation	$192	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than	No charge	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
	requesting dentist or physician		
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	No charge	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$95	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No charge	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	No charge	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$28	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$81	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	No charge	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$32	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$234	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$52	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$264	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9999	Unspecified adjunctive procedure, by report	$59	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

Base metal is the Benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are

referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an Optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Additional Endnotes to Covered California's 2019 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

1. Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.

2. In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.

3. In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.

4. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.* Additional requests, beyond the stated frequency limitations, for prophylaxis [D1110, D1120], fluoride [D1206, D1208] and scaling [D4346] procedures shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

2. A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown [covered codes only between D2710-D2791] is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation

4. The replacement of an existing crown [covered codes only between D2710-D2791], fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or a removable full or partial denture [covered codes only between D5211-D5214, D5221-D5224] is covered when:

   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and

   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

5. Coverage for the placement of a fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or removable partial denture [covered codes only between D5211-D5214, D5221-D5224]:

   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
      - Each abutment tooth to be crowned meets Limitation #3.

   b. Removable partial denture:
      - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

6. Excision of the frenum [D7960] is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

7. A new removable partial [covered codes only between D5211-D5214, D5221-D5224] or complete [D5110-D5140] or covered immediate denture [D5130, D5140] includes after delivery

adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

8. Immediate dentures [D5130, D5140, D5221–D5224] are covered when one or more of the following conditions are present:

   a. Extensive or rampant caries are exhibited in the radiographs, or

   b. Severe periodontal involvement indicated, or

   c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

9. Maxillofacial prosthetic services [covered codes only between D5911-D5999] for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

10. All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior authorization for medically necessary procedures.

11. Implant services [covered codes only between D6010-D6199] are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.

    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.

    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

12. Temporomandibular joint dysfunction procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.

13. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

14. Deep sedation/general anesthesia [D9222, D9223] or intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

<u>Exclusions of Benefits for Pediatric Enrollees</u>

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures [covered codes only between D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224], space maintainers [D1510–

D1575], crowns [D2390, D2710–D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] covered codes only between or other appliances.

4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

   b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the *"Emergency Dental Services"* and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call the Delta Dental's Customer Care at 800-422-4234.

10. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120–D0999] for non-covered Benefits.

11. Single tooth implants [covered codes only between D6000–D6199].

12. Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative [covered codes only between D2140-D2999] procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures [covered codes only between D5211-5214, D5221-D5224] are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these [covered codes only between D2510-D2664, D2710-D2794, D6205-D6252, D6710-D6794] is considered to be full mouth reconstruction under this Plan. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.

17. Porcelain denture teeth, precision abutments for removable partials [page 5-60, D5862] or fixed partial dentures (overlays, implants, and appliances associated therewith) [page 5-78, D6940, D6950] and personalization and characterization of complete and partial dentures.

18. Extraction of teeth [D7111, D7140, D7210, D7220-D7240], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

19. TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6711-D6791], orthodontia [covered codes only between D8000–D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.

20. Vestibuloplasty / ridge extension procedures [D7340, D7350] performed on the same date of service as extractions on the same arch.

21. Deep sedation/general anesthesia [D9222, D9223] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia [D9239, D9243].

22. Intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia [D9222, D9223].

23. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.

24. Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D2330–D2394, D6211-D6245, D6251, D6721-D6791, D8000-D8999].

25. Orthodontic treatment [covered codes only between D8000–D8999] must be provided by a licensed dentist. Self-administered orthodontics are not covered (section 3, page 3-1, enrollment requirements).

26. The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered benefit (page 5-105, #1).

<u>Medically Necessary Orthodontic for Pediatric Enrollees</u>

1. Coverage for comprehensive orthodontic treatment [D8080] requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts [D0470]. Comprehensive orthodontic treatment [D8080]:
   a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b) may start at birth for patients with a cleft palate or craniofacial anomaly.

2. Removable appliance therapy [D8210] or fixed appliance therapy [D8220] is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

3. The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0351]. Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment examination.

4. The number of covered periodic orthodontic treatment [D8670] visits and length of covered active orthodontics is limited to a maximum of up to:

a. Handicapping malocclusion - Eight (8) quarterly visits;

b. Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;

c. Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or

d. Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.

e. Facial growth management – Four (4) quarterly visits for treatment of primary dentition;

f. Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;

g. Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention [D8680] is a separate Benefit after the completion of covered comprehensive orthodontic treatment [D8080] which:

   a. Includes removal of appliances and the construction and place of retainer(s) [D8680]; and

   b. Is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

   An adjustment of an orthodontic retainer is included in the fee for the retainer for the first six months after delivery.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment [covered codes only between D8000–D8999]. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and

   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment [covered codes only between D8000–D8999], the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

   a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

   b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

   At the end of 60 days (or at the end of the Quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Covered pediatric dental services apply to the out-of-pocket maximum in your WHA EOC. See your WHA EOC for information about your out-of-pocket maximum.
(D) Professional Services	An Enrollee may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Share, subject to the limitations and exclusions of the program. Cost Share ranges by category of service. Examples are as follows: Diagnostic Services — No Charge Preventive Services — No Charge Restorative Services — $ 33.00 - $ 646.00 Endodontic Services — $ 36.00 - $ 629.00 Periodontic Services — $ 24.00 - $ 399.00 Prosthodontic Services, Removable — $ 43.00 - $ 1,222.00 Maxillofacial Prosthetics — $150.00 - $ 5,317.00 Implant Services (medically necessary only) — $ 56.00 - $ 1,648.00 Prosthodontic Services, Fixed — $ 67.00 - $ 717.00 Oral and Maxillofacial Surgery — $ 37.00 - $ 5,863.00 Orthodontic Services (medically necessary only) — No charge - $ 3,768.00 Adjunctive General Services — No charge - $ 264.00 NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period; Replacement of a crown is limited to once every 5+ years (60+ months) for Pediatric Enrollees.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Cost Share that is shown in the *Description of Benefits and Cost Share for Pediatric Benefits* in this Amendment.