

## Dental Health Care Plan

TX10I

### *Evidence of Coverage*

*Provided by:*

Alpha Dental Programs, Inc.  
1130 Sanctuary Parkway, Suite 600  
Alpharetta, GA 30009  
800-422-4234

*Administered by:*

Delta Dental Insurance Company  
P.O. Box 1803  
Alpharetta, GA 30023  
800-422-4234



# EVIDENCE OF COVERAGE

## Introduction

DeltaCare® USA Dental Health Care Plan (“Plan”)

This Evidence of Coverage (“EOC”) for Your DeltaCare USA HMO Dental Health Care Plan (“Plan”) is provided by Alpha Dental Plans, Inc. (“Company”), on behalf of itself, and its affiliated companies. The Plan has been established and is administered in accordance with the provisions of the Group Dental Service Contract (“Contract”) issued by Us.

This document, including the Contract and any attachments, provides the terms and conditions of Your Plan’s coverage. Read this document carefully for an explanation of Your coverage, including the *Definitions* section for any terms with special or technical meanings.

Terms such as “You,” “Your” and “Yourself” means the individuals who are covered. “We,” “Us” and “Our” refers to the Company or Our Third Party Administrator (“Administrator”).

### Identification Card (ID)

ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification (“ID”) number should be provided to Your Dentist. An ID card may be obtained by visiting Our website at [deltadentalins.com](http://deltadentalins.com).

### Contract

The Benefit explanations contained in this EOC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the EOC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act (“ERISA”).

### Contact Us

For more information, visit Our website at [deltadentalins.com](http://deltadentalins.com) or call the Customer Service at 800-422-4234 or You may submit an inquiry to:

DeltaCare USA Customer Service  
P.O. Box 1803  
Alpharetta, GA 30023

**Please read the following information so that You will know how to obtain dental services.**

**You must obtain dental Benefits from Your Contract Dentist or be referred for Specialist Services.**

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## Definitions

Certain terms used throughout this document begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your Benefits and how the dental Program works.

**Administrator:** Delta Dental Insurance Company or other entity designated by Us, and operating as an Administrator in the state of Texas. Certain functions described in this EOC may be performed by the Administrator, as designated by Us.

**Authorization:** The process by which We determine if a procedure or treatment is a referable Benefit under Your Program.

**Benefits:** Dental services available to you under this Plan and described in this EOC, the Contract and Schedules. See also Schedules

**Calendar Year:** The period of time, which starts January 1 and ends December 31 of each year.

**Contractholder:** The group that enters into or executes the Contract to obtain dental coverage.

**Contract Dentist:** A Dentist who provides services in general dentistry and who has agreed to provide Benefits under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist Services must be obtained from Your Contract Dentist.

**Contract Orthodontist:** A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

**Contract Specialty Care Dentist:** A Dentist who provides Specialized Services and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

**Contract Term:** The period during which coverage is in effect whether on a Calendar or Contract Year basis.

**Contractholder:** The group that enters into or executes this Contract to obtain dental coverage.

**Copayment:** The amounts You are responsible to pay the treating Dentist as set forth in *Schedule A*. Copayments must be paid at the time treatment is received.

**Dependents ("Dependent Enrollees"):** The Primary Enrollee's eligible Dependents and any Individuals eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- The Spouse
- Dependent children other than grandchildren from birth to age 26.
- Your unmarried grandchild, younger than 25 years of age, and dependent for federal income tax purposes at the time application for the grandchild is made. Coverage for a grandchild may not be terminated solely because the grandchild's parent is no longer dependent upon You for federal income tax purposes. Newborn infants are eligible from the moment of birth.
- Adopted children are eligible from the time You are a party in an adoption suit for such children.
- Newborn and adopted child will automatically be covered 31 days after birth or adoption. For coverage to continue after the 31-day period, verbal or written notice of birth or notice regarding the adoption suit and any additional Premium, if any, must be received within the 31-day period.
- As otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder.

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

**Effective Date:** The date the Contract becomes effective or coverage begins.

**Emergency Dental Services:** Procedures provided in a Dentist's facility, emergency dental clinic or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity accomplished by excessive bleeding, severe pain or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

**Enrollee ("Primary Enrollee"):** Employee or an Dependent ("Dependent Enrollee") enrolled to receive Benefits.

**Grace Period:** A period of no less than 31 days after the Premium payment is due under the Contract, in which a payment may be made and during which coverage will continue in effect, subject to the Premium payment by the end of the Grace Period.

**Open Enrollment Period:** The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

**Optional Treatment:** Any alternative procedure that satisfies the same dental need as a covered procedure and is chosen by You subject to the limitations and exclusions of the Contract.

**Out-of-Network:** Treatment by a Dentist who has not signed a contract with Us to provide Benefits under this Plan. Also referred to as Non-participating Dentist.

**Plan:** Dental Benefits selected by the Contractholder and provided under the Contract, EOC and any attachments.

**Premium:** Payment made in consideration of dental coverage.

**Schedules:** Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:

- *Schedule A, Description of Benefits and Copayments, and*
- *Schedule B, Limitations and Exclusions of Benefits*

**Service Area:** A geographic area where We are approved to provide dental coverage. Refer to the Texas Service Area attachment for a listing of the counties in Our Service Area and a copy of Our Service Area map.

**Special Enrollment Period:** The period of time outside Your Open Enrollment Period during which individuals eligible as Primary Enrollees or Dependents who experience certain qualifying events may enroll in this Plan.

**Specialist Services** mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by ALPHA.

**Spouse:** An individual who is a partner of the Primary Enrollee as:

- Defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;



- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- May be recognized by the Contractholder.

## **Eligibility and Enrollment - When Coverage Begins**

### **Eligibility Requirements**

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported by the Contractholder. You are eligible to enroll if you meet the eligibility requirements defined by the Contractholder.

Eligibility is determined by the Contractholder. We do not make eligibility determinations. We will update Our files to record the eligibility information provided by the Contractholder or its designee.

Your Dependents are eligible to enroll on the same date that You enroll. Later-acquired Dependents become eligible as soon as they acquire dependent status.

Dependents that reside, live or work in Our Service Area become eligible:

- On the date You are eligible for coverage;
- As soon as Your later acquired dependents acquire dependent status; or
- At any time subject to a change in legal custody or medical or dental support order, regardless of whether the Dependent resides outside Our Service Area.

Eligibility may be delayed for young children, under the age of 4, until the beginning of any Contract Term immediately following the child's birthday. For coverage to begin on young children, the eligibility notice and additional Premium payment must be received by Us within 30 days of the beginning of the Contract Term immediately following the child's birthday.

Children/students must be dependent upon You for support and maintenance.

There is no coverage under this Plan for Dependents on active military duty.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

## **Children under Medical and Dental Support Orders**

Coverage is extended to any child who is recognized under a medical or dental support order regardless of where the child resides. The parent or custodial parent, legal authority or the child may request Dependent coverage under Your coverage. Coverage is automatic for the first 31 days after receipt or notice of such order. An additional premium may be required for the initial 31-day period of coverage. In order for coverage to continue beyond the initial 31-day period, additional premium may be required. Documentation of the medical or dental support order must be furnished upon request.

Children receiving coverage outside Our Service Area will be comparable to dental coverage provided to children in Our Service Area. Comparable dental coverage may include coverage in which the Plan uses different procedures for service delivery and health care provider reimbursement, but may not include coverage that is:

- 1) Limited to Emergency Dental Services only, or
- 2) Charged a higher premium.

## **Overage Dependent Children**

An overage Dependent child may be eligible if:

- The child is incapable of self-sustaining employment because of a physically or intellectually disabling injury, illness or condition that began prior to reaching the limiting age;
- The child is chiefly dependent on the Primary Enrollee for support; and
- Proof of disability is provided within 60 days of request. Proof of disability will not be required more than one (1) time per year following a two (2) year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition that began before the Dependent child reached the limiting age.

## **Enrollment Requirements**

If the Contractholder is responsible for Your Premium, coverage will begin on the Contract's Effective Date. If You are responsible for Your Premium:

- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The eligibility date for such children may be delayed as outlined in the *Eligibility for Benefits* section.

You:

- Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
- May not drop coverage and may only make coverage changes during an Open Enrollment Period or Special Enrollment Period as a result of a qualifying status change.

A Dependent may not be enrolled under more than one Primary Enrollee.

A child who is eligible as a Primary Enrollee and a Dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

### **Special Enrollment Periods - Enrollment Changes**

After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:

- Marital status (Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death);
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status);
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125; or
- Any other changes specified by applicable law or regulation.

### **Premiums**

You are required to contribute towards the cost of Your coverage and the cost of Your Dependent's coverage, if applicable.

## How to Use the DeltaCare USA HMO Plan

### Choice of Contract Dentist Facility

We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You must select a Contract Dentist from the list of Dentists provided at [deltadentalins.com](http://deltadentalins.com). If You fail to select a Contract Dentist, or the Contract Dentist selected becomes unavailable, We will request the selection of another Contract Dentist or will assign You to another Contract Dentist.

We will provide You written notice of the assignment to another Contract Dentist provided Your Contract Dentist:

- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents be re-assigned to another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:

- Partial or full dentures for which final impressions have been taken
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Inquiries regarding availability of appointments and accessibility of Dentists should be directed to Our Customer Service department. If You live in Our Service Area and there is no Contract Dentist within 75 miles, You have the right to self-refer to an Out-of-Network Dentist to obtain Benefits. Prior authorization or referral authorization is not necessary. We will reimburse the Out-of-Network Dentist at the Contract Dentist reimbursement or in-network Benefit level. Copayments may apply, please refer to *Schedule A*.

### Contract Dentist Termination

If Your assigned Contract Dentist no longer participates in this Plan, the Contract Dentist will complete all treatment in progress as described above.

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the

termination of the agreement. For example, the terminating Contract Dentist will complete:

- A partial or full denture for which final impressions have been taken; or
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If, for any reason, the Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of such dental treatment by another Contract Dentist.

### **Coordination of Care and Referrals**

Services must be provided by the Contract Dentist assigned to You or a Contract Specialty Care Dentist or Contract Orthodontist upon referral by the Contract Dentist and authorized by Us. We have no obligation or liability with respect to services provided by Out-of-Network Dentists when Contract Dentists are available to provide such services with the exception of Emergency Dental Services or Specialized Services referred by a Contract Dentist. All authorized Specialized Services claims will be paid less any applicable Copayments.

If there is no Contract Dentist within 75 miles, You may self-refer to a Non-Contracted Dentist for Benefits. If there is no Contract Specialty Care Dentist or Contract Orthodontist within 75 miles, the Contract Dentist may refer you to a Non-Contracted Specialist or You may self-refer to a Non-Contracted Dentist or Non-Contracted Orthodontist for specialty care.

If Your Contract Dentist has questions about Your eligibility or Benefits, refer the Contract Dentist to Us.

### **Benefits, Limitations and Exclusions**

This Plan provides Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached Schedules. Only services, supplies or procedures listed in the Schedules and deemed appropriate by Your Contract Dentist are covered under this Plan. Contract Dentists may provide services directly or through associated Dentists, technicians or hygienists who may lawfully perform the services.

You may obtain treatment for benefits even though You are unable to undergo dental treatment in an office setting or under local

anesthesia due to a documented physical, mental, or medical reason as determined by Your physician or Dentist providing the dental service.

## **Copayments and Other Charges**

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the Schedules, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan. Certain procedures require You to pay a Copayment. Copayments are listed in the Schedules and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the Schedules.

Should We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received 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 Dentist for the cost of services. For further clarification, see "*Emergency Services*".

## **Medically Necessary Services**

If medically necessary services, other than emergency care, are not available within Our Service Area, at the Contract Dentist's request and receipt of reasonably requested documentation, and within the time appropriate to the circumstances, but in no event no later than five (5) business days, We will allow a referral to an Out-of-Network Dentist. We will fully reimburse the Out-of-Network Dentist at the usual and customary or an agreed rate. Copayments may apply, please refer to *Schedule A*.

This requirement does not apply if You live in Our Service Area and there is no Contracted Dentists or Contracted Specialists or Contract Orthodontists within 75 miles of Your home address, You may self-refer to an Out-of-Network Dentist in this instance. Prior authorization is not necessary. We will reimburse the Out-of-Network Dentist at the Contract Dentist or Contract Specialty Care Dentist or Contract Orthodontist reimbursement or in-network Benefit level. Copayments may apply, please refer to *Schedule A*.

## **Specialized Services**

Specialized and Orthodontic Services that are medically necessary must be referred by the assigned Contract Dentist and authorized by

Us within (5) five business days. All authorized Specialized Services will be paid by Us less any applicable Copayments. We will authorize the referral of an Out-of-Network Dentist within (5) five business days after receipt of reasonably requested documentation.

If You need Specialized Services and there is no Contract Specialty Care Dentist or Contract Orthodontist to provide these services within 75 miles of Your home address, the assigned Contract Dentist is NOT required to receive Authorization from Us to refer You to an Out-of-Network Dentist to provide the Specialized Services. You may self-refer to an Out-of-Network Dentist without receiving a referral from Your Contracted Dentist. We will reimburse the Out-of-Network Dentist at the Contract Specialty Care Dentist or Contract Orthodontist reimbursement or in-network Benefit level. Prior authorization is not necessary. Copayments may apply, please refer to *Schedule A*.

If You need services from a Contract Orthodontist, please refer to Orthodontics in the *Schedule A* and *Schedule B* to determine which procedures are covered under this Program.

### **Emergency Dental Services**

If you have a dental emergency, You should contact Your Contract Dentist whenever possible. Contract Dentists maintain a twenty-four (24) hour Emergency Services system seven (7) days a week. If You are unable to reach Your Contract Dentist for Emergency Services, contact Customer Service at 800-422-4234 for assistance in obtaining urgent care.

You may seek immediate treatment from a Dentist other than Your Contract Dentist with no referral for Emergency Dental Services, and we will reimburse You for the cost of Emergency Dental Service(s) which exceeds Your Copayment(s). If You receive emergency care services and a bill for Emergency Dental Services contact Customer Service at 800-422-4234.

Emergency Dental Services are limited to listed procedures as described in code D9110 "Palliative (emergency) treatment of dental Plan." Further treatment must be obtained from the assigned Contract Dentist. (Refer to *Schedule A* and *Schedule B*).

### **Claims for Reimbursement**

Claims for covered Emergency Dental Services, authorized Specialized Services or Out-of-Network Services or if You self-refer to an Out-of-Network Dentist as outlined above must be submitted to Us 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 claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department  
P.O. Box 1810  
Alpharetta, GA 30023

Payment of claims will be as follows:

- Within 15 days after receipt of the claim, We will:
  - \* Acknowledge receipt of the claim;
  - \* Initiate an investigation of the claim; and
  - \* Request any necessary information necessary to adjudicate the claim.
- No later than 15 days after request of any requested information, We will notify You:
  - \* Of the acceptance or rejection of the claim and the reason, if rejected; or
  - \* That additional time is necessary to adjudicate the claim and the reason for the delay.
- No later than the 45 days after You have been notified of the need for additional time needed to make a decision, We will accept or reject the claim. Accepted claims will be paid no later than the fifth (5th) business day following notice of acceptance.
- If payment is subject to performance of an act by You, the claim will be paid no later than the fifth (5th) business day after the date the act is performed.

In the event We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us.

Except for *Emergency Dental Services* and self-referrals outlined above, if You have not received 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 Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Dental Services* and *Specialized Services*.

## **Coordination of Benefits ("COB")**

If You and Your Dependents are covered by another dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this Plan is the "primary" plan, We will not reduce Benefits. If this plan is the "secondary" plan, We may



reduce Benefits to that the total Benefits paid or provided by all plans do not exceed 100% of total allowable expense.

But if this plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

**In Order to determine which Plan is primary, We will use the following rules.**

- The plan covering You as an employee or Primary Enrollee is primary over a plan covering You as a dependent.
- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - \* Secondary to the plan covering You as a dependent; and
  - \* Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.
- Except as stated in the immediate above paragraph, when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:
  - \* The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
  - \* If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
  - \* However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.
- In the case of a dependent child of legally separated or divorced parents, the plan covering the child as a dependent of the parent with legal custody or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the child as a dependent of the parent without legal custody.
- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial

responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.

- If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.
- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
  - \* First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
  - \* Second, the Benefits under the continuation coverage.
  - \* If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

### **Renewal and Termination of Benefits**

This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date that this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

## Cancellation of Enrollment

Subject to the *Continuation of Coverage under USERRA* and *Continuation of Coverage under COBRA* provisions, Your enrollment may be canceled, or renewal of enrollment refused, in the following events:

- As of the date the Contract is terminated.
- You or Your dependents cease to be eligible under the terms of the Plan.
- Immediately subject to continuation of coverage provisions, for failure to meet eligibility requirements other than where You reside, live or work in Our Service Area.
- If You engage in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility.
- Upon 15 days written notice if You:
  - Knowingly commit or permit another person to commit fraud or deception in obtaining Benefits; or
  - Commit fraud in the use of services or facilities.
- Upon at least 30 days written notice for:
  - For nonpayment of Premium by You or on Your behalf;
  - If You do not reside, live or work in Our Service Area without regard to any health status-related factor. However, coverage for a child who is the subject of a medical or dental support order will not be cancelled solely on basis the child does not reside, live or work in Our Service Area.
  - You fail to pay Copayments. You may be reinstated during the term of the Contract upon payment of all delinquent copayment charges; or
  - A satisfactory dentist-patient relationship fails to be established with multiple contract facilities. We must show that We have, in good faith, provided You with the opportunity to select an alternative Contract Dentist. If You establish a history of unsatisfactory relationships, We will provide written notice to You at least 30 days in advance, explaining the dentist-patient relationship to be unsatisfactory. We will also specify the changes that are necessary in order to avoid cancellation, and show You have failed to make these changes.

We will not pay for services received after Your coverage ends. However for treatment in progress, We will continue to provide Benefits less any applicable Copayments.

For information related to the right to continue coverage, at Your own expense, refer to the *Optional Continuation of Coverage* provision.

If We cancel your coverage for any other reason or if You cancel coverage by giving Us 30 days' advance written notice because:

- No Contract Dentist is available to You,
- You move out of the DeltaCare USA Service Area, or
- You change to coverage under a different group Plan, We will, within 30 days, return to You the pro-rata portion of the Premium paid for any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to Us. **Otherwise no refunds will be made.**

Cancellation of Your enrollment will automatically cancel the enrollment of any of Your Dependents.

## **General Provisions**

### **Compliance with Administrative Simplification, Security and Privacy Regulations**

The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties agree that this Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

### **Conformity with Prevailing Laws**

All legal questions about the Contract will be governed by laws of the state where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the state or federal law is hereby amended to conform to the requirements of such laws.

### **Entire Contract; Changes**

The Contract, including this EOC, Schedules and any attachments, represents the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

### **Incontestability**

After the Contract has been in force for 2 years from the Effective Date, no statement made by the Contractholder will be used to void

the Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 2 years or more during the Your lifetime.

No claims for loss incurred or disability commencing after two (2) years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

### **Legal Actions**

No action at law or in equity will be brought to recover on the Contract prior to expiration of sixty (60) days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

### **Misstatements on Application; Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

### **Processing Policies**

The *Schedules* explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by these Dentists are provided subject to any Copayments. You may contact Our Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

### **Severability**

If any part of the Contract, this EOC, Attachments or an Amendment to any of these documents is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

### **Strike, Lay-off and Leave of Absence**

You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 ("FMLA") or other applicable state or federal law\*.

\*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon Your return to active work as if no interruption occurred.

**Important:** FMLA does not apply to all organizations, only those that meet certain size guidelines. Refer to Your Human Resources unit for complete information.

## **Optional Continuation of Group Coverage**

If Your coverage ceases for any reason other than involuntary termination for cause, and You have been continuously covered for at least three (3) consecutive months immediately prior to such termination, You may request continuation of coverage for Yourself and Your covered Dependents, subject to the following requirements:

Continuation must be requested in writing and received by the Contractholder no later than the 60th day following the later of the date:

- Coverage would otherwise terminate, or
- You are provided notice of the right to elect continuation.

If You elect continuation coverage, you must:

- Pay the monthly amount of contribution required for continuation coverage, plus 2% of the amount of the group rate for coverage being continued under the group contract, and
- Make payment no later than the 45th day after the initial election, and on the due date of each payment thereafter. Following this payment, subsequent payments will be considered timely if made by the 30th day after the date on which payment is due.

## **Termination of Your Continued Coverage**

Continued coverage will terminate on the earliest of the following:

- The date You are not eligible for continuation of coverage under COBRA:
  - \* At the end of the nine (9) month period after the date the election to continue coverage is made; or
  - \* Six (6) additional months following any period of continuation provided under COBRA;
- The date You fail to remit required contributions in a timely manner;

- If Your coverage is being continued, the date You become covered for similar benefits under any Plan arranged by any other group; or
- The date on which the Contract is terminated in its entirety.

The Contractholder must notify Us within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

### **Termination of the Contractholder's Dental Plan**

If the Contract terminates prior to the time that Your continuation of coverage ends, the Contractholder must notify You either:

- Thirty (30) days prior to the termination; or
- When all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the Contractholder's subsequent dental Plan.

Continuation of coverage will only be provided for the balance of the time You would have remained covered under Our Plan had the former plan not terminated.

### **Continuation of Coverage under USERRA**

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 1) Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- 2) The date You fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

### **Continuation of Coverage under COBRA**

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

## Non-Discrimination

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

We provide free:

- Provide 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)
- Provide 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 Our Customer Service department at 800-422-4234. If You believe that We have 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:

DeltaCare USA  
18000 Studebaker Road, Suite 530  
Cerritos, CA 90703  
Telephone Number: 800-422-4234  
Website Address: [deltadentalins.com](http://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, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

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



SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025, procedure codes, descriptors or nomenclature that are 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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>YOU PAY</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient .....	No Cost
D0140	Limited oral evaluation - problem focused .....	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	No Cost
D0150	Comprehensive oral evaluation - new or established patient .....	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report .....	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) .....	No Cost
D0171	Re-evaluation - post-operative office visit .....	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient .....	No Cost
D0190	Screening of a patient .....	No Cost
D0191	Assessment of a patient .....	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.</i> ....	No Cost

D0220	Intraoral - periapical first radiographic image .....	No Cost
D0230	Intraoral - periapical each additional radiographic image .....	No Cost
D0240	Intraoral - occlusal radiographic image .....	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector .....	No Cost
D0251	Extraoral posterior dental radiographic image .....	No Cost
D0270	Bitewing - single radiographic image .....	No Cost
D0272	Bitewings - two radiographic images .....	No Cost
D0273	Bitewings three radiographic images .....	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i> .....	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images .....	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i> .....	No Cost
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw .....	\$110.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible .....	\$110.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium .....	\$110.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium .	\$150.00
D0396	3D printing of a 3D dental surface scan .....	No Cost
D0415	Collection of microorganisms for culture and sensitivity .....	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i> .....	No Cost
D0425	Caries susceptibility tests .....	No Cost
D0460	Pulp vitality tests .....	No Cost
D0470	Diagnostic casts .....	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report .....	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report .....	No Cost

D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report .....	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i> .....	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i> .....	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i> .....	No Cost
D0701	Panoramic radiographic image - image capture only .....	No Cost
D0702	2-D cephalometric radiographic image - image capture only .....	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only .....	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only .....	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only .....	No Cost
D0707	Intraoral - periapical radiographic image - image capture only .....	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only .....	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only .....	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> .....	No Cost

## **D1000-D1999                      II. PREVENTIVE**

D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 D1110, D1120 or D4346 per 6 month period</i> .....	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult ( <i>within the 6 month period</i> ) .....	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 D1110, D1120 or D4346 per 6 month period</i> .....	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child ( <i>within the 6 month period</i> ) .....	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i> .....	No Cost

D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i> .....	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions .....	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i> .....	\$5.00
D1354	Application of caries arresting medicament - per tooth - <i>child to age 19; 1 per 6 month period</i> .....	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$10.00
D1516	Space maintainer - fixed - bilateral, maxillary .....	\$10.00
D1517	Space maintainer - fixed - bilateral, mandibular .....	\$10.00
D1520	Space maintainer - removable - unilateral - per quadrant .....	\$10.00
D1526	Space maintainer - removable - bilateral, maxillary .	\$10.00
D1527	Space maintainer - removable - bilateral, mandibular .....	\$10.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary .....	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular .....	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant .....	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant .....	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary .....	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular .....	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i> .....	\$10.00

**D2000-D2999****III. RESTORATIVE**

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, You may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent .....	No Cost
D2150	Amalgam - two surfaces, primary or permanent ....	No Cost
D2160	Amalgam - three surfaces, primary or permanent ..	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent .....	No Cost
D2330	Resin-based composite - one surface, anterior .....	No Cost
D2331	Resin-based composite - two surfaces, anterior ....	No Cost
D2332	Resin-based composite - three surfaces, anterior ...	No Cost
D2335	Resin-based composite - four or more surfaces (anterior) .....	No Cost
D2390	Resin-based composite crown, anterior .....	No Cost
D2391	Resin-based composite - one surface, posterior ....	\$45.00
D2392	Resin-based composite - two surfaces, posterior ...	\$55.00
D2393	Resin-based composite - three surfaces, posterior .	\$65.00
D2394	Resin-based composite - four or more surfaces, posterior .....	\$75.00
D2510	Inlay - metallic - one surface .....	No Cost
D2520	Inlay - metallic - two surfaces .....	No Cost
D2530	Inlay - metallic - three or more surfaces .....	No Cost
D2542	Onlay - metallic - two surfaces .....	No Cost
D2543	Onlay - metallic - three surfaces .....	No Cost
D2544	Onlay - metallic - four or more surfaces .....	No Cost
D2610	Inlay - porcelain/ceramic - one surface .....	\$135.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	\$150.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ..	\$160.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	\$150.00
D2643	Onlay - porcelain/ceramic - three surfaces .....	\$165.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ..	\$175.00
D2650	Inlay - resin-based composite - one surface .....	\$85.00
D2651	Inlay - resin-based composite - two surfaces .....	\$95.00

D2652	Inlay - resin-based composite - three or more surfaces .....	\$115.00
D2662	Onlay - resin-based composite - two surfaces .....	\$110.00
D2663	Onlay - resin-based composite - three surfaces .....	\$120.00
D2664	Onlay - resin-based composite - four or more surfaces .....	\$145.00
D2710	Crown - resin-based composite (indirect) .....	\$35.00
D2712	Crown - 3/4 resin-based composite (indirect) .....	\$35.00
D2720	Crown - resin with high noble metal .....	\$155.00
D2721	Crown - resin with predominantly base metal .....	\$55.00
D2722	Crown - resin with noble metal .....	\$95.00
D2740	Crown - porcelain/ceramic .....	\$195.00
D2750	Crown - porcelain fused to high noble metal .....	\$195.00
D2751	Crown - porcelain fused to predominantly base metal .....	\$95.00
D2752	Crown - porcelain fused to noble metal .....	\$135.00
D2753	Crown - porcelain fused to titanium and titanium alloys .....	\$195.00
D2780	Crown - 3/4 cast high noble metal .....	\$170.00
D2781	Crown - 3/4 cast predominantly base metal .....	\$70.00
D2782	Crown - 3/4 cast noble metal .....	\$110.00
D2783	Crown - 3/4 porcelain/ceramic .....	\$195.00
D2790	Crown - full cast high noble metal .....	\$170.00
D2791	Crown - full cast predominantly base metal .....	\$70.00
D2792	Crown - full cast noble metal .....	\$110.00
D2794	Crown - titanium and titanium alloys .....	\$195.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration .....	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core .....	No Cost
D2920	Re-cement or re-bond crown .....	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp ( <i>anterior</i> ) .....	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth .....	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i> .....	\$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost

D2931	Prefabricated stainless steel crown - permanent tooth .....	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i> .	\$15.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i> .....	\$10.00
D2940	Placement of interim direct restoration .....	No Cost
D2949	Restorative foundation for an indirect restoration ..	No Cost
D2950	Core buildup, including any pins when required .....	No Cost
D2951	Pin retention - per tooth, in addition to restoration .	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> .....	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> .....	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i> .....	No Cost
D2956	Removal of an indirect restoration on a natural tooth .....	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i> .....	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. ....	\$19.00
D2976	Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i> .....	No Cost
D2980	Crown repair necessitated by restorative material failure .....	\$10.00
D2981	Inlay repair necessitated by restorative material failure .....	\$10.00
D2982	Onlay repair necessitated by restorative material failure .....	\$10.00
D2983	Veneer repair necessitated by restorative material failure .....	\$10.00
D2989	Excavation of a tooth resulting in the determination of non-restorability .....	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to 1 per 24 months</i> .....	\$5.00

#### **D3000-D3999                      IV. ENDODONTICS**

D3110	Pulp cap - direct (excluding final restoration) .....	No Cost
D3120	Pulp cap - indirect (excluding final restoration) .....	No Cost

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament .....	No Cost
D3221	Pulpal debridement, primary and permanent teeth	\$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .....	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) .....	\$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) .....	\$5.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) .....	\$45.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) .....	\$90.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration) .....	\$205.00
D3331	Treatment of root canal obstruction; non-surgical access .....	\$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth .....	\$45.00
D3333	Internal root repair of perforation defects .....	\$45.00
D3346	Retreatment of previous root canal therapy - anterior .....	\$60.00
D3347	Retreatment of previous root canal therapy - premolar .....	\$105.00
D3348	Retreatment of previous root canal therapy - molar .....	\$220.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) .....	\$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) .....	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$45.00
D3410	Apicoectomy - anterior .....	No Cost
D3421	Apicoectomy - premolar (first root) .....	No Cost
D3425	Apicoectomy - molar (first root) .....	No Cost
D3426	Apicoectomy (each additional root) .....	No Cost



D3430	Retrograde filling - per root .....	No Cost
D3450	Root amputation - per root .....	No Cost
D3471	Surgical repair of root resorption - anterior .....	No Cost
D3472	Surgical repair of root resorption - premolar .....	No Cost
D3473	Surgical repair of root resorption - molar .....	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar .....	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ...	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy .....	No Cost
D3921	Decoronation or submergence of an erupted tooth	No Cost

#### **D4000-D4999                      V. PERIODONTICS**

*- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$80.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth .....	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$80.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$50.00
D4245	Apically positioned flap .....	\$75.00
D4249	Clinical crown lengthening - hard tissue .....	\$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$175.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$140.00

D4263	Bone replacement graft - retained natural tooth - first site in quadrant .....	\$195.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant .....	\$60.00
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site .....	\$305.00
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site .....	\$283.00
D4270	Pedicle soft tissue graft procedure .....	\$195.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft .....	\$650.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) .....	\$45.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft .....	\$310.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft .....	\$195.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site .....	\$195.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site .....	\$410.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site .....	\$155.00
D4286	Removal of non-resorbable barrier .....	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost

D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i> .....	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> .....	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i> .....	No Cost
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i> .....	\$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant .....	No Cost

<b>D5000-D5899</b>		<b>VI. PROSTHODONTICS (removable)</b>
<ul style="list-style-type: none"> <li>- <i>For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.</i></li> <li>- <i>Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.</i></li> <li>- <i>Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.</i></li> </ul>		
D5110	Complete denture - maxillary .....	\$100.00
D5120	Complete denture - mandibular .....	\$100.00
D5130	Immediate denture - maxillary .....	\$120.00
D5140	Immediate denture - mandibular .....	\$120.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) .....	\$120.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) .....	\$120.00

D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$80.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$120.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$120.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery ...	\$170.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .....	\$170.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	\$80.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) .....	\$80.00
D5410	Adjust complete denture - maxillary .....	No Cost
D5411	Adjust complete denture - mandibular .....	No Cost
D5421	Adjust partial denture - maxillary .....	No Cost
D5422	Adjust partial denture - mandibular .....	No Cost
D5511	Repair broken complete denture base, mandibular .	\$15.00
D5512	Repair broken complete denture base, maxillary ....	\$15.00
D5520	Replace missing or broken teeth - complete denture - per tooth .....	\$5.00
D5611	Repair resin partial denture base, mandibular .....	\$15.00
D5612	Repair resin partial denture base, maxillary .....	\$15.00
D5621	Repair cast partial framework, mandibular .....	\$15.00
D5622	Repair cast partial framework, maxillary .....	\$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth .....	\$15.00
D5640	Replace missing or broken teeth - partial denture - per tooth .....	\$5.00
D5650	Add tooth to existing partial denture - per tooth ....	\$5.00
D5660	Add clasp to existing partial denture - per tooth ....	\$5.00

D5670	Replace all teeth and acrylic on cast metal framework (maxillary) .....	\$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular) .....	\$75.00
D5710	Rebase complete maxillary denture .....	\$35.00
D5711	Rebase complete mandibular denture .....	\$35.00
D5720	Rebase maxillary partial denture .....	\$35.00
D5721	Rebase mandibular partial denture .....	\$35.00
D5725	Rebase hybrid prosthesis .....	\$35.00
D5730	Reline complete maxillary denture (chairside) .....	No Cost
D5731	Reline complete mandibular denture (chairside) ....	No Cost
D5740	Reline maxillary partial denture (chairside) .....	No Cost
D5741	Reline mandibular partial denture (chairside) .....	No Cost
D5750	Reline complete maxillary denture (laboratory) .....	\$35.00
D5751	Reline complete mandibular denture (laboratory) ..	\$35.00
D5760	Reline maxillary partial denture (laboratory) .....	\$35.00
D5761	Reline mandibular partial denture (laboratory) .....	\$35.00
D5765	Soft liner for complete or partial removable denture - indirect .....	\$35.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i> .....	\$45.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i> .....	\$45.00
D5850	Tissue conditioning, maxillary .....	No Cost
D5851	Tissue conditioning, mandibular .....	No Cost

## **D5900-D5999                      VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

## **D6000-D6199                      VIII. IMPLANT SERVICES**

- *The following are limited to no more than two (2) each per calendar year: Implants, Implant supported prosthetics and Implant abutments.*

- *Replacement of crowns, bridges and implant supported dentures requires the existing restoration to be 5+ years old.*

*\* Name brand, laboratory processed or in-office processed crowns/ pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional*

*fee not to exceed \$150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*

D6010	Surgical placement of implant body: endosteal implant .....	\$1,005.00
D6011	Surgical access to an implant body (second stage implant surgery) .....	\$145.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant .....	\$390.00
D6013	Surgical placement of mini implant .....	\$340.00
D6040	Surgical placement: eposteal implant .....	\$940.00
D6050	Surgical placement: transosteal implant .....	\$920.00
D6055	Connecting bar - implant supported or abutment supported .....	\$345.00
D6056	Prefabricated abutment - includes modification and placement .....	\$330.00
D6057	Custom fabricated abutment - includes placement .....	\$425.00
D6058	Abutment supported porcelain/ceramic crown .....	\$740.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	\$750.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	\$610.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	\$710.00
D6062	Abutment supported cast metal crown (high noble metal) .....	\$720.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	\$545.00
D6064	Abutment supported cast metal crown (noble metal) .....	\$690.00
D6065	Implant supported porcelain/ceramic crown .....	\$780.00
D6066	Implant supported crown - porcelain fused to high noble alloys .....	\$750.00
D6067	Implant supported crown - high noble alloys .....	\$730.00
D6068	Abutment supported retainer for porcelain/ceramic FPD .....	\$725.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	\$750.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) .....	\$485.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	\$660.00

D6072	Abutment supported retainer for cast metal FPD (high noble metal) .....	\$750.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal) .....	\$415.00
D6074	Abutment supported retainer for cast metal FPD (noble metal) .....	\$425.00
D6075	Implant supported retainer for ceramic FPD .....	\$780.00
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys .....	\$750.00
D6077	Implant supported retainer for metal FPD - high noble alloys .....	\$750.00
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments - <i>limited to 1 per calendar year</i> .....	\$65.00
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure - <i>limited to 1 per 24 months</i> .....	\$65.00
D6082	Implant supported crown - porcelain fused to predominantly base alloys .....	\$610.00
D6083	Implant supported crown - porcelain fused to noble alloys (noble metal) .....	\$710.00
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys .....	\$655.00
D6086	Implant supported crown - predominantly base alloys .....	\$545.00
D6087	Implant supported crown - noble alloys .....	\$690.00
D6088	Implant supported crown - titanium and titanium alloys .....	\$655.00
D6089	Accessing and retorquing loose implant screw - <i>limited to 1 per 24 months</i> .....	\$50.00
D6090	Repair of implant/abutment supported prosthesis - <i>limited to 1 per calendar year</i> .....	\$130.00
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment - <i>limited to 1 per calendar year</i> .....	\$60.00
D6092	Re-cement or re-bond implant/abutment supported crown .....	\$72.00

D6093	Re-cement or re-bond implant/abutment supported fixed partial denture .....	\$95.00
D6094	Abutment supported crown - titanium and titanium alloys .....	\$655.00
D6096	Remove broken implant retaining screw - <i>limited to 1 per calendar year</i> .....	\$50.00
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys .....	\$655.00
D6098	Implant supported retainer - porcelain fused to predominantly base alloys .....	\$485.00
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys .....	\$660.00
D6100	Surgical removal of implant body - <i>limited to 1 per calendar year</i> .....	\$245.00
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure - <i>limited to 1 per calendar year</i> ...	\$125.00
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure - <i>limited to 1 per calendar year</i> .....	\$240.00
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure - <i>limited to 1 per calendar year</i> .....	\$290.00
D6104	Bone graft at time of implant placement - <i>limited to 1 per calendar year</i> .....	\$290.00
D6105	Removal of implant body not requiring bone removal or flap elevation - <i>limited to 1 per calendar year</i> .....	No Cost
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary .....	\$925.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular .....	\$925.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary .....	\$1,015.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular .....	\$1,015.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary .....	\$925.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular .....	\$925.00



D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary .....	\$1,015.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular .....	\$1,015.00
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys .....	\$415.00
D6121	Implant supported retainer for metal FPD - predominantly base alloys .....	\$415.00
D6122	Implant supported retainer for metal FPD - noble alloys .....	\$425.00
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys .....	\$620.00
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments - <i>Once in a calendar year</i> .....	\$65.00
D6190	Radiographic/surgical implant index, by report - <i>limited to 1 per calendar year</i> .....	\$165.00
D6193	Replacement of an implant screw - <i>Once in a 24 month period</i> .....	\$72.00
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys .....	\$620.00
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys .....	\$750.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant - <i>limited to 1 in 24 months</i> .....	No Cost
D6198	Remove interim implant component .....	No Cost

**D6200-D6999                      IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

- *When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional \$100.00 per unit, beyond the 6th unit.*

- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

D6210	Pontic - cast high noble metal .....	\$170.00
D6211	Pontic - cast predominantly base metal .....	\$70.00
D6212	Pontic - cast noble metal .....	\$110.00
D6240	Pontic - porcelain fused to high noble metal .....	\$195.00

D6241	Pontic - porcelain fused to predominantly base metal .....	\$95.00
D6242	Pontic - porcelain fused to noble metal .....	\$135.00
D6243	Pontic - porcelain fused to titanium and titanium alloys .....	\$135.00
D6245	Pontic - porcelain/ceramic .....	\$195.00
D6250	Pontic - resin with high noble metal .....	\$155.00
D6251	Pontic - resin with predominantly base metal .....	\$55.00
D6252	Pontic - resin with noble metal .....	\$95.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces ....	\$150.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces .....	\$160.00
D6602	Retainer inlay - cast high noble metal, two surfaces .....	\$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces .....	\$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces .....	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces .....	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces .....	\$40.00
D6607	Retainer inlay - cast noble metal, three or more surfaces .....	\$40.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces ....	\$150.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces .....	\$165.00
D6610	Retainer onlay - cast high noble metal, two surfaces .....	\$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces .....	\$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces .....	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces .....	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces ....	\$40.00
D6615	Retainer onlay - cast noble metal, three or more surfaces .....	\$40.00
D6720	Retainer crown - resin with high noble metal .....	\$155.00
D6721	Retainer crown - resin with predominantly base metal .....	\$55.00

D6722	Retainer crown - resin with noble metal .....	\$95.00
D6740	Retainer crown - porcelain/ceramic .....	\$195.00
D6750	Retainer crown - porcelain fused to high noble metal .....	\$195.00
D6751	Retainer crown - porcelain fused to predominantly base metal .....	\$95.00
D6752	Retainer crown - porcelain fused to noble metal ....	\$135.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys .....	\$195.00
D6780	Retainer crown - 3/4 cast high noble metal .....	\$170.00
D6781	Retainer crown - 3/4 cast predominantly base metal .....	\$70.00
D6782	Retainer crown - 3/4 cast noble metal .....	\$110.00
D6783	Retainer crown - 3/4 porcelain/ceramic .....	\$195.00
D6784	Retainer crown - 3/4 titanium and titanium alloys ..	\$170.00
D6790	Retainer crown - full cast high noble metal .....	\$170.00
D6791	Retainer crown - full cast predominantly base metal .....	\$70.00
D6792	Retainer crown - full cast noble metal .....	\$110.00
D6930	Re-cement or re-bond fixed partial denture .....	No Cost
D6940	Stress breaker .....	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure .....	\$10.00

## **D7000-D7999                      X. ORAL AND MAXILLOFACIAL SURGERY**

*- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

D7111	Extraction, coronal remnants - primary tooth .....	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .....	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated .....	\$15.00
D7220	Removal of impacted tooth - soft tissue .....	\$25.00
D7230	Removal of impacted tooth - partially bony .....	\$50.00
D7240	Removal of impacted tooth - completely bony .....	\$70.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications .....	\$90.00
D7250	Removal of residual tooth roots (cutting procedure) .....	No Cost

D7251	Coronectomy - intentional partial tooth removal, impacted teeth only .....	\$90.00
D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i> .....	\$15.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth .....	\$50.00
D7280	Exposure of an unerupted tooth .....	\$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption .....	\$85.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	No Cost
D7284	Excisional biopsy of minor salivary glands - <i>does not include pathology laboratory procedures</i> .....	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm .....	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm .....	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible) .	No Cost
D7472	Removal of torus palatinus .....	No Cost
D7473	Removal of torus mandibularis .....	No Cost
D7509	Marsupialization of odontogenic cyst .....	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue .....	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site .....	No Cost
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach - <i>limited to 1 per calendar year; only covered in conjunction with the surgical placement of implant</i> .....	\$850.00

D7952	Sinus augmentation via a vertical approach - <i>limited to 1 per calendar year; only covered in conjunction with the surgical placement of implant</i>	\$640.00
D7953	Bone replacement graft for ridge preservation - per site - <i>limited to 1 per lifetime; only covered in conjunction with the surgical placement of implant</i>	\$100.00
D7961	Buccal/labial frenectomy (frenulectomy) .....	No Cost
D7962	Lingual frenectomy (frenulectomy) .....	No Cost
D7970	Excision of hyperplastic tissue - per arch .....	\$50.00
D7971	Excision of pericoronal gingiva .....	\$50.00

**D8000-D8999                      XI. ORTHODONTICS**  
*- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.*  
*- The Retention Copayment includes adjustments and/or office visits up to 24 months.*

***Pre and post orthodontic records include:***  
*The Benefit for pre-treatment records and diagnostic services includes: .....* \$200.00

D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0322	Tomographic survey	
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	

	<i>The Benefit for post-treatment records includes: ....</i>	\$70.00
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition .....	\$950.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$950.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$1,900.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i> .....	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development .....	\$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers) .....	\$275.00
D8681	Removable orthodontic retainer adjustment .....	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> .....	\$100.00

## **D9000-D9999                      XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative treatment of dental pain - per visit .....	\$5.00
D9211	Regional block anesthesia .....	No Cost
D9212	Trigeminal division block anesthesia .....	No Cost

D9215	Local anesthesia in conjunction with operative or surgical procedures .....	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia .....	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes .....	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment .....	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes .....	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment ..	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician .....	No Cost
D9311	Consultation with a medical health care professional .....	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed ....	\$5.00
D9440	Office visit - after regularly scheduled hours .....	\$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning .....	No Cost
D9912	Pre-visit patient screening .....	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary .....	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular .....	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary .....	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular .....	No Cost
D9941	Fabrication of athletic mouthguard .....	\$110.00
D9943	Occlusal guard adjustment .....	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$95.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$95.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> .....	\$95.00
D9951	Occlusal adjustment, limited .....	\$20.00
D9952	Occlusal adjustment, complete .....	\$40.00

D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i> .....	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i> .....	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i> .....	\$10.00
D9990	Certified translation or sign-language services - per visit .....	No Cost
D9991	Dental case management - addressing appointment compliance barriers .....	No Cost
D9992	Dental case management - care coordination .....	No Cost
D9995	Teledentistry - synchronous; real-time encounter ...	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review ....	No Cost
D9997	Dental case management - Patients with special Health Care Needs .....	No Cost

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.



## SCHEDULE B

### Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$150.00 in addition to the listed Copayment. Contact the Customer Service Center at 800-422-4234 if you have questions regarding the additional fee or name brand services.
5. Benefits provided by a pediatric Dentist are limited to children through age 13 less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
6. The cost to You receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

7. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
8. Fabrication of athletic mouthguard is limited to once every 12 months.
9. If any existing fixed bridge or removable denture that already replaces the tooth or teeth, which would be replaced by a new implant-supported prosthesis, that existing appliance must be eligible for replacement under the terms of the Contract.
10. Replacement of implants and implant-supported prosthesis requires the existing implants and implant-supported prosthesis to be 5+ years old.
11. Implants and implant supported crowns and prosthesis are covered to replace one or more natural permanent teeth lost due to accidental trauma or removal.
12. Implant removal is limited to one (1) for each implant during Your lifetime.
13. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.
14. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign<sup>TM</sup> and Sure Smile<sup>TM</sup>). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).
15. X-ray Limitations:
  - When the frequencies for the comprehensive radiographic images (D0210) and panoramic images (D0330) differ, the least restrictive frequency will apply.

- Panoramic images are not considered part of a comprehensive intraoral series.
  - Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
  - Bitewing x-rays are limited to two images for under age 10.
  - Image capture procedures are not separately billable services.
16. The fee for accessing and retorquing a loose implant screw is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis.

## Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
  - \* has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - \* is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Implant and implant-supported crowns and appliances are not covered Benefits for You and Dependent Enrollees under 19 years of age.
7. An implant-supported prosthesis with one abutment supported by a natural tooth and the second supported by an implant are not covered.
8. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
9. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant, unless listed as a covered Benefit.
10. Consultations for non-covered Benefits.

11. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Dental Services* as described in Schedule A.
12. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
13. Prescription drugs.
14. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
15. Lost, stolen or broken orthodontic appliances.
16. Changes in orthodontic treatment necessitated by accident of any kind.
17. Myofunctional and parafunctional appliances and/or therapies.
18. Orthodontic treatment must be provided by a licensed Dentist.
19. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
20. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment.

## GLOSSARY

The following dental terms have the meanings indicated:

**Abrasion** - The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

**Alveoloplasty** - A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

**Amalgam** - A metal alloy used in filling teeth.

**Apicoectomy** - The surgical removal of the root tip.

**Appliance** - A device used to provide function or therapeutic effect.

**Attrition** - The normal loss of tooth substance resulting from friction during chewing.

**Banding** - Application of preformed stainless steel rings that are fitted around the teeth and cemented in place.

**Banding dentition** - Treatment of a tooth which involves banding (for orthodontic purposes).

**Cephalometric x-rays** - X-rays used in studying the measurements of the head in relation to specific soft tissue and bony reference points.

**Cleft palate** - A birth defect resulting in an incomplete closure or formation of the palate.

**Debridement** - The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

**Equilibration** - Changing the occlusal forms of the teeth by selective grinding, with the interest of balancing occlusal stresses more evenly on the teeth.

**Erosion** - Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

**Exostosis** - An excessive growth of bone.

**Expansion appliance** - An appliance used to widen a dental arch to increase the room available for permanent teeth and/or to correct the bite.

**Frenum** - The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

**Frenectomy** - Surgical removal or loosening of the frenum.

**Functional appliance** - An appliance used to achieve minor tooth movement, to strengthen the muscles of the oral cavity or to maintain space created by the loss or delayed eruption of the teeth.

**Gingiva** - The soft tissue which covers a tooth or the gum surrounding a tooth.

**Gingivectomy** - The surgical removal of the unsupported gingiva to the level where it is attached.

**Gingivoplasty** - Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

**Headgear** - An apparatus encircling the head or neck that provides attachment for an intraoral appliance in use of extraoral anchorage.

**Implant** - A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

**Lingual** - Pertaining to the tongue.

**Macrognathia** - A definite overgrowth of the mandible and maxilla.

**Mandible** - The lower jaw.

**Mandibular** - Pertaining to the lower jaw.

**Maxilla** - The upper jaw.

**Maxillary** - Pertaining to the upper jaw.

**Micrognathia** - An abnormal smallness of the jaws, especially the mandible.

**Myofunctional therapy** - Training to curb or eliminate abnormal muscle function of the oral cavity.

**Occlusal** - The chewing surfaces of the posterior teeth.

**Occlusion** - The contact between the upper and lower teeth when in a closed position.

**Orthodontic appliance** - Any appliance used to apply forces for tooth movement during orthodontic treatment.

**Palate** - The roof of the mouth.

**Palatal** - Pertaining to the roof of the mouth.

**Palliative** - Action that relieves pain but does not cure the cause of the pain.

**Panoramic film** - An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

**Pediatric** or **Pedodontic** - Pertaining to children.

**Periapical** - The area surrounding or enclosing the root tip of a tooth.

**Periodontitis** - Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

**Periradicular** - Around the root.

**Pontic** - The term used for the artificial tooth on a bridge.

**Prophylaxis** - The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

**Pulp cap** - The covering of an exposed dental nerve with material that protects it from foreign irritants.

**Quadrant** - One of the four equal sections into which the dental arches can be divided; begins at the middle of the arch and goes to the last tooth on either side.

**Rebase** - Process of refitting a denture by replacing the acrylic base material.

**Resin** - Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.



**Retainer** - An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

**Retrograde filling** - A method of sealing the root canal by preparing and filling it from the root tip.

**Root planing** - A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as "deep cleaning."

**Sealant** - Application of a resin material to the biting surfaces of the permanent molars to seal the surface crevices to prevent the formation of decay.

**Study model** - A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

**Supernumerary** - Any tooth in excess of the 32 normal permanent teeth.

**Temporomandibular joint** - The joint formed by the connection of the lower jaw to the skull.

**Tracing** - As it relates to orthodontic treatment, a tracing is a line drawing of pertinent features of a cephalometric x-ray made on a piece of transparent paper placed over an x-ray. The tracing provides measurements of soft tissue and bony reference points that aid in predicting growth patterns and orthodontic diagnosis and treatment planning.

**Trigeminal nerve** - The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

**Vertical dimension** - The vertical height of the face with teeth in occlusion.

## TEXAS SERVICE AREA

The following is a county listing of the approved Service Area for Alpha Dental Programs, Inc. and a map of the Service Area.

Anderson	Coke	Garza	Karnes	Montague	Starr
Andrews	Coleman	Gillespie	Kaufman	Montgomery	Stephens
Angelina	Collin	Glasscock	Kendall	Moore	Sterling
Aransas	Colorado	Goliad	Kenedy	Morris	Stonewall
Archer	Comal	Gonzales	Kent	Nacogdoches	Sutton
Armstrong	Comanche	Gray	Kerr	Navarro	Swisher
Atascosa	Concho	Grayson	Kimble	Newton	Tarrant
Austin	Cooke	Gregg	King	Nolan	Taylor
Bailey	Coryell	Grimes	Kinney	Nueces	Terry
Bandera	Cottle	Guadalupe	Kleberg	Oldham	Throckmorton
Bastrop	Crane	Hale	Knox	Orange	Titus
Baylor	Crockett	Hamilton	La Salle	Palo Pinto	Tom Green
Bee	Crosby	Hardeman	Lamar	Panola	Travis
Bell	Dallas	Hardin	Lamb	Parker	Trinity
Bexar	Dawson	Harris	Lampasas	Parmer	Tyler
Blanco	DeWitt	Harrison	Lavaca	Pecos	Upshur
Borden	Deaf Smith	Hartley	Lee	Polk	Upton
Bosque	Delta	Haskell	Leon	Potter	Uvalde
Bowie	Denton	Hays	Liberty	Presidio	Van Zandt
Brazoria	Dickens	Henderson	Limestone	Rains	Victoria
Brazos	Dimmit	Hidalgo	Live Oak	Randall	Walker
Brewster	Donley	Hill	Lubbock	Reagan	Waller
Briscoe	Duval	Hockley	Llano	Real	Ward
Brooks	Eastland	Hood	Loving	Red River	Washington
Brown	Ector	Hopkins	Lynn	Refugio	Webb
Burleson	El Paso	Houston	Madison	Robertson	Wharton
Burnet	Ellis	Howard	Marion	Rockwall	Wichita
Caldwell	Erath	Hudspeth	Martin	Runnels	Wilbarger
Calhoun	Falls	Hunt	Mason	Rusk	Willacy
Callahan	Fannin	Hutchinson	Matagorda	San Augustine	Williamson
Cameron	Fayette	Irion	Maverick	San Jacinto	Wilson
Camp	Fisher	Jack	McCulloch	San Patricio	Winkler
Carson	Floyd	Jackson	McLennan	San Saba	Wise
Cass	Foard	Jasper	McMullen	Sabine	Wood
Castro	Fort Bend	Jeff Davis	Medina	Schleicher	Yoakum
Chambers	Franklin	Jefferson	Menard	Scurry	Young
Cherokee	Freestone	Jim Hogg	Midland	Shackelford	Zapata
Childress	Frio	Jim Wells	Milam	Shelby	Zavala
Clay	Gaines	Johnson	Mills	Smith	
Cochran	Galveston	Jones	Mitchell	Somervell	

The following counties are not part of the Alpha Dental Programs, Inc. Service Area:

Collingsworth, Culberson, Dallam, Edwards, Hall, Hansford, Hemphill, Lipscomb, Motley, Ochiltree, Reeves, Roberts, Sherman, Terrell, Val Verde, Wheeler.

### Map

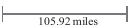


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## Service Areas

■ TDI Approved Counties

Approved April 15, 2019



### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### **Alpha Dental Programs**

To get information or file a complaint with your insurance company or HMO:

**Call: Quality Management**

**1-800-422-4234**

**Toll Free: 1-800-422-4234**

Online: [deltadentalins.com](http://deltadentalins.com)

Mail: P.O. Box 1803

Alpharetta, GA 30023

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question:

1-800-252-3439

File a complaint:

[www.tdi.texas.gov](http://www.tdi.texas.gov)

Email:

[ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail:

MC: CO-CP

Texas Department of Insurance

PO Box 12030

Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### **Alpha Dental Programs**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Quality Management**

**1-800-422-4234**

**Teléfono gratuito: 1-800-422-4234**

En línea: [deltadentalins.com](http://deltadentalins.com)

Dirección postal: P.O. Box 1803

Alpharetta, GA 30023

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al:

1-800-252-3439

Presente una queja en:

[www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico:

[ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal:

MC: CO-CP

Texas Department of Insurance

PO Box 12030

Austin, TX 78711-2030

## HMO Notice of Rights

- A health maintenance organization (HMO) plan provides no benefits for services You receive from Out-of-Network Dentists, with specific exceptions as described in the Contract and this notice.
- You have the right to an adequate network of in-network Dentists (also known as network Dentists).
- If You believe that Our network is inadequate, You may file a complaint with the Texas Department of Insurance at: [www.tdi.texas.gov/consumer/complfrm.html](http://www.tdi.texas.gov/consumer/complfrm.html).
- If We approve a referral for Out-of-Network services because no in-network Dentist is available, or if You have received Out-of-Network Emergency Dental Services, We must, in most cases, resolve the Out-of-Network Dentist's bill so that You only have to pay any applicable in-network Copayment, Coinsurance, and Deductible amounts.
- You may obtain a current directory of in-network Dentists by visiting Our website at [deltadentalins.com](http://deltadentalins.com) or calling Our Customer Service department at 800-422-4234 for assistance in finding available in-network Dentists. If You relied on materially inaccurate directory information, You may be entitled to have a claim by an Out-of-Network Dentist paid as if it were from a network Dentist, if You present a copy of the inaccurate directory information to Us, dated not more than 30 days before You received the service.

# **COMPLAINT AND APPEAL PROCEDURE**

## **Definitions**

**Adverse Determination:** A determination that services provided or proposed are not medically necessary or appropriate or are Experimental or Investigational.

**Appeal of Adverse Determination or Appeal:** Is the formal process by which You, Your Representative or Your provider may request reconsideration of an Adverse Determination.

**Complaint:** An oral or written expression of dissatisfaction or disagreement with any aspect of Our organization's operations. It does not include:

- An Appeal;
- An oral or written expression of dissatisfaction or disagreement with an Adverse Determination from You or Your provider; or
- A misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to Your satisfaction.

**Complainant:** You, Your designated representative, physician, or provider.

**Emergency Dental Services:** Procedures provided in a Dentist's facility, emergency dental clinic or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity accomplished by excessive bleeding, severe pain or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

**You:** Includes You and Your Dependents.

You may call Customer Service at 800-422-4234, or write to:

Quality Management Department  
P.O. Box 1860  
Alpharetta, GA 30023

**Complaint Information**

Written Complaints must include: 1) Name of the patient; 2) Name, address, telephone number and Enrollee ID number; and 3) Dentist's name and facility location.

Within five (5) business days of receipt, Your Complaint will be acknowledged along with a description of our procedures and resolution time frames. If You filed an oral Complaint, You will be provided a one page Complaint form to complete and return.

If the Complaint involves Emergency Dental Services, the Complaint will be resolved as soon as practical, but no later than one (1) business day after receipt of the Complaint. Non-Emergency Dental Complaints will be resolved no later than 30 calendar days after receipt.

A written resolution letter will include:

- An explanation of the resolution including the clinical reason and/or contractual reasons for the resolution;
- The specialization of any Dentist or other provider consulted; and
- A complete description of the Appeal process, including deadlines for the final decision.

**Complaint Appeal**

If Your Complaint is not resolved to Your satisfaction, You or Your designated representative or Your provider may Appeal the decision. Within five (5) business days of receipt of Your Appeal request, You will receive acknowledgement of the date of receipt and Your right to:

- Appear in person before a panel at the site You receive services or at an agreed upon location; or
- Submit a written Appeal to the Complaint Appeal panel.

If the Enrollee is a minor or disabled, You or Your designated representative is entitled to:

- Appear in person before the panel;
- Present alternative expert testimony; or
- Request the presence of and question those responsible for the disputed resolution.

No later than five (5) business days before the scheduled meeting of the panel, unless You agree otherwise, You will be provided with:

- Any documentation to be presented to the panel;
- The specialization of providers consulted during the investigation of the Appeal; and
- The name and affiliation of Our representatives on the panel.

Upon Your request, instead of the Complaint Appeal panel, Your Appeal will be reviewed by a provider who has not previously reviewed the case, and who is of the same or similar specialty as ordinarily manages the procedure or treatment under Appeal. You or Your designated representative may be interviewed by this provider who will render a decision on the Appeal. Initial notice of decision of the Appeal may be delivered orally followed by written notice within three (3) days.

Written notice of the decision will be provided no later than the 30<sup>th</sup> calendar day after receipt.

Emergency Dental Services will be concluded no later than one (1) business day after receipt or earlier in accordance with the dental immediacy of the case and will include:

- A statement of the specific dental determination, clinical basis and any contractual criteria used to reach the decision; and
- The toll-free telephone number and address of the Texas Department of Insurance.



## **Adverse Determination Information**

A written notice of an Adverse Determination will be provided to You, Your designated representative and the provider who rendered the service. The notice will include:

- The principal reasons and clinical basis for the Adverse Determination;
- A description or the source of the screening criteria utilized as guidelines in making the determination;
- The professional specialty of the Dentist that made the Adverse Determination;
- A description of the Appeal procedure including Your right to Appeal to an Adverse Determination to an Independent Review Organization (“IRO”);
- The procedures for obtaining a review and a copy of the independent review request form, which is also available at [www.tdi.texas.gov/forms](http://www.tdi.texas.gov/forms); and
- For enrollees with life-threatening conditions, the right to an immediate review by an IRO.

If Your Appeal involves a life threatening condition, You are entitled to an immediate review by an IRO and are not required to comply with procedures for obtaining an internal review by Us.

## **Adverse Determination Appeal**

You, Your designated representative or the provider of record may request an Appeal of an Adverse Decision within 90-180 days of receipt of Your Adverse Determination either orally or in writing.

Written Appeals must include: 1) Name of the patient; 2) Name, address, telephone number and ID number of the Enrollee; and 3) Dentist’s name and facility location.

Within 5 business days after receipt of Your Appeal, You will be sent a letter acknowledging the date of receipt, and a description of Our procedures. If You filed an oral Appeal, You will be provided a one page Appeal form to complete and return.

Appeals concerning Emergency Dental Services will be resolved within one business day after receipt. Non-Emergency Dental Appeals will be resolved within 30 calendar days after receipt. A written notice will be provided to You of the resolution and include:

- A statement of the specific clinical and/or contractual reasons for the resolution;
- The specialty of the Dentist or other provider consulted; and
- A description of Our Appeal procedures, including how to file an independent review, along with a copy of the independent review request form. The form is also available at [www.tdi.texas.gov/forms](http://www.tdi.texas.gov/forms).

Notice of our decision on an Appeal will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

### **Independent Review**

If You are not satisfied with the Appeal resolution, or if the Appeal relates to emergency care denials, denials of care for life-threatening conditions, or denials of continued stays for hospitalization, You have the right to file for review by an IRO. You, Your designated representative, or Your provider may request an independent review by submitting a *REQUEST FOR A REVIEW BY AN IRO* form to the Administrator. Upon receipt You will be provided notice to the appropriate agency within one (1) working day. Within three (3) working days, the IRO will be provided copies of all relevant documents. We will comply with the IROs determination relating to medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services requested by You.

**Texas Department of Insurance:** You may file a Complaint with the Texas Department of Insurance ("TDI") at P.O. Box 149091, Austin, Texas 78714-9091. The Department's toll-free telephone number is 800-252-3439. The TDI will investigate within 60 days of receipt of Your Complaint and

all information necessary to determine compliance. The TDI may extend the time necessary to complete an investigation if additional information is needed or an on-site review is necessary or other circumstances exist beyond their control.

**Retaliatory Action Prohibited:** We will not engage in any retaliatory action against the Contractholder, You, or Your Provider for filing a Complaint or appealing a decision.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضاً للحصول على هذا المستند تكموباً بلغتك للمساعدة لمجانبة اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

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क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձևով լեզվով: Անվճար օգնություն համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសាបស្ចិមលោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט,עמעצער דאָ קען אייך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין אייער שפראך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אָט די דאזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóoltahígíí nihee hółó. Díí naaltsoos t'áá Diné bizaad k'éhjí ályaago ałdó' nich'í' ádoolnǫ́go bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojí' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)



If you have any questions or need additional information, call or write:

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800-422-4234

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