

Dental Health Care Program  
for Eligible Employees  
and Dependents

Combined Evidence of Coverage and  
Disclosure Form

**STATE OF MARYLAND**

**MDD57**

*Provided by:*

**Delta Dental of Pennsylvania**

One Delta Drive  
Mechanicsburg, PA 17055

*Administered by:*

**Delta Dental Insurance Company**

P.O. Box 1803  
Alpharetta, GA 30023  
844-697-0578

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

In Maryland, DeltaCare® USA is underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

# EVIDENCE OF COVERAGE

## DISCLOSURE FORM

### **DeltaCare® USA Dental Health Care Program**

This booklet is a Combined Evidence of Coverage and Disclosure Form (“EOC”) for your DeltaCare USA Dental Health Care Program (“Program”) provided by Delta Dental of Pennsylvania (“Delta Dental”). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract (“Contract”) issued by Delta Dental.

This EOC describes the provisions of the Contract between your group and Delta Dental. This EOC provides coverage for dental services and Benefits as a Dental Plan Organization in accordance with the terms and conditions specified in the Contract.

**THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.**

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 844-697-0578. Customer Service representatives are available between 8 a.m.-8 p.m. Eastern time, Monday-Friday.

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## Definitions

As used in this booklet:

**Administrator** means Delta Dental Insurance Company (“Delta Dental”) or other entity designated by Delta Dental of Pennsylvania, operating as an Administrator in the state of Maryland. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 844-697-0578 between 8 a.m.-8 p.m. Eastern time, Monday-Friday.

**Authorization** means the process by which the Administrator determines if a procedure or treatment is a referable Benefit under the Enrollee’s plan.

**Benefits** mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

**Contract Dentist** means a Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Program.

**Contract Orthodontist** means a Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Program.

**Contract Specialist** means a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program.

**Copayment** means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

**Eligible Dependent** means any dependent of an Eligible Employee who is eligible for Benefits as recognized by the Group and/or state law.

**Eligible Employee** means any employee or group member who is eligible for Benefits as recognized by the Group and/or state law.

**Emergency Services** mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee’s health in serious jeopardy.

**Enrollee** means an Eligible Employee (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.

**Group** means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

**Open Enrollment Period** means the period of time during the year in which Eligible Employees/retirees can make a change in their Benefits.

**Optional** means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee and is subject to the limitations and exclusions of the Contract.

**Out-of-Network** means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under the terms of the Contract.

**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 the Administrator.

**We, Us or Our** means Delta Dental or the Administrator, as appropriate.

## **Eligibility for Benefits**

Eligible Employees and Eligible Dependents (includes children up to age 26) receive Benefits as soon as they are enrolled in the Program.

Eligible Dependents become eligible on:

- 1) the date you are eligible for coverage;
- 2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. Coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO). If employee is not currently enrolled, we shall enroll both the employee and the child, without regard to enrollment period restrictions, within 20 business days of receipt of a child medical support order. If the employee is currently enrolled and a child is eligible for enrollment, we shall complete the enrollment without regard to enrollment period restrictions, within 20 business days of receipt of a child medical support order.

Coverage for a child covered by a medical support order will remain in effect unless written evidence is provided to Delta Dental that:

- 1) the order is no longer in effect;
- 2) the child has been, or will be, enrolled under other reasonable dental insurance coverage that will take effect on or before the effective date of the termination;
- 3) the employer has eliminated dependent coverage for all of its employees;  
or
- 4) the Primary Enrollee is no longer eligible for coverage, except that the Primary Enrollee may then elect continuation coverage for the child under COBRA, if applicable.

Notwithstanding any limiting age stated in this EOC, any unmarried child covered under this EOC as a dependent of an Enrollee who is chiefly dependent for support upon the Enrollee, and who, at the time of reaching

the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under this EOC while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage on the Enrollee upon whom the child is dependent terminates.

Dependents on active military duty are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee/retiree. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

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

After the effective date, you can change your enrollment during the Open Enrollment Period. There are also special enrollment periods when the Primary Enrollee may add or remove himself/herself and his/her Dependent Enrollees. These life change events include:

- 1) birth of a child or grandchild;
- 2) adoption of a child;
- 3) court order of placement or custody of a child;
- 4) loss of other coverage;
- 5) marriage or other lawful union between two adults.

If you enrolled, or are eligible to enroll, a new dependent or yourself as a result of one of these events, you must supply the required enrollment change information to your Group within 60 days of the date of the life change event. The dependent must meet the definition of Eligible Dependent as determined by State of Maryland.

The Primary Enrollee may also add or remove dependents or change plans for the reasons defined by and during the timeframes specified by applicable law or regulation.

Except for newborn or adopted children, coverage for the new dependent will begin on the date specified in the enrollment information provided to us as long as the premium is paid.

Newborns of an Enrollee may be enrolled from the moment of birth. Adopted children may be enrolled from the date of adoption or placement, except for those adopted or placed within 60 days of birth who may be a Dependent Enrollee from the moment of birth. In order for coverage of newborn or adopted children to continue beyond the first 60 day period, if additional premium is required to cover a newly enrolled dependent child, the child's enrollment information must be provided to us and the required premium must be paid. A minor for whom guardianship is granted by court or testamentary appointment may be enrolled from the date of appointment.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union, reaching the limiting age or during Open Enrollment Periods.

## **Late Enrollment**

If you or your dependent(s) are not enrolled within 60 days of initial eligibility or during the special enrollment period specified for a life change event, you or your dependent(s) cannot enroll until the next special enrollment period or Open Enrollment Period. If you are required by court order to provide coverage for a dependent child, you will be permitted to enroll the dependent child without regard to enrollment season restrictions.

## **Voluntary Disenrollment**

If you choose to drop your coverage or your dependent's coverage under this Program at any time during the contract term or during the Open Enrollment Period, you will only be permitted to reenroll yourself or your dependents during a future Open Enrollment Period or upon the occurrence of a qualifying status change.

## **Premiums**

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction or paid directly to the Group. The Group will be responsible for sending all payments of premiums to us.

## **How to use the DeltaCare USA Program - Choice of Contract Dentist**

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, the Administrator will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 844-697-0578 between 8 a.m.-8 p.m. Eastern time, Monday-Friday. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment, you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should

be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 844-697-0578.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST REFERRED BY A CONTRACT DENTIST, OR FOR EMERGENCY SERVICES REQUIRED DURING NON-BUSINESS HOURS, WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY OR WHEN THE ENROLLEE IS UNABLE TO REACH THEIR CONTRACT DENTIST. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM, WITH THE FOLLOWING EXCEPTION:

If, during the term of the Contract, none of the Contract Dentists can render necessary care and treatment to the Enrollee due to circumstances not reasonably within the control of Delta Dental or the Administrator, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes or the disability of a significant number of the Contract Dentists, then the Enrollee may seek treatment from an independent licensed Dentist of his/her own choosing. The Administrator will pay the Enrollee for the expenses incurred for the dental services with the following limitations: the Administrator will pay the Enrollee for services which are listed in the *Description of Benefits and Copayments*, as No Cost, to the extent that such fees are reasonable and customary for Dentists in the same geographic area; the Administrator will also pay the Enrollee for those services listed in the *Description of Benefits and Copayments* for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services provided under this Program. The Enrollee may be required to give written proof of loss. Delta Dental and the Administrator agree to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by Contract Dentists.

## **Benefits, Limitations and Exclusions**

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. The Administrator relies on the professional judgment of the general Dentist to diagnose the appropriate efficient and prudent solution to your dental needs based on the plan Benefits. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

## **Copayments and Other Charges**

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.



## **Emergency Services**

You should contact your assigned Contract Dentist for Emergency Services for covered dental procedures whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 844-697-0578 between 8 a.m.-8 p.m. Eastern time, Monday-Friday for assistance in obtaining urgent care. During non-business hours, or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of \$100.00 per Enrollee, per emergency. You are responsible for the Copayment(s) as well as any charges over the \$100.00 benefit maximum. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be authorized by Delta Dental or obtained from the assigned Contract Dentist.

## **Specialist Services**

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist and authorized by the Administrator. All authorized Specialist Services will be paid by us less any applicable Copayments.

We will authorize continuing care from a specialist if your Contract Dentist determines that you have a life-threatening, degenerative, chronic or disabling dental condition or dental disease that requires continuing care from a specialist. We will authorize a referral to a specialist who is not a Contract Specialist if 1) you are diagnosed with a condition or disease that requires specialized health care services or medical care; and 2) we do not have a Contract Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or 3) we cannot provide reasonable access to a Contract Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

If the assigned Contract Dentist refers you to a specialist who is not a Contract Specialist for covered dental services, we will be responsible for payment of the specialist's charges that exceed the Copayment specified in the Contract. You will only be liable for the same fees and/or Copayments that you would pay to a Contract Specialist for the same treatment.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and limitations and exclusions to determine which procedures are covered under this Program.

Services provided by a health care professional not listed within this section are not covered.

## Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to the Administrator 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. Except in the absence of legal capacity of the claimant, all claims must be received within one year from the time proof is otherwise required. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist or Contract Specialist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have received unauthorized treatment from an Out-of-Network Dentist, you will be liable to that Dentist for the cost of services. For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

If you are treated by an Out-of-Network Dentist for:

- 1) an emergency (subject to the *Emergency Services* provisions described above); or
- 2) specialized dental care and are referred to an Out-of-Network specialist because the Administrator does not have a Contract Specialist with the professional training or expertise in treating that particular dental disease or condition; or
- 3) specialized dental care and are referred to an Out-of-Network specialist because no Contract Specialist is available to provide the required services without unreasonable delay or travel; then you shall only be liable for the same fees and/or Copayments that you would pay to a Contract Dentist for the same treatment. These Copayments can be found in *Schedule A*.

We will provide a noninsuring parent with membership cards, claim forms and any other information necessary for a child covered by a medical support order to receive benefits under this Program. If a non-insuring parent incurs expenses for covered Emergency Services or authorized Specialist Services provided to this child, we will process claims for such services and make payment to the noninsuring parent, health care provider or Department of Health and Mental Hygiene as appropriate.

## Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with any similar benefits provided by any other group dental insurance policy or any group dental benefits program.

The determination of which policy or program is primary shall be governed by the following rules:

- 1) The policy or program covering the Enrollee as other than a dependent shall be primary over the policy or program covering the Enrollee as a dependent.
- 2) The policy or program covering the Enrollee as an employee is primary over a policy or program covering the insured person as a dependent; except that if the insured person is 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:
  - a) Secondary to the policy or program covering the insured person as a dependent; and
  - b) Primary to the policy or program covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the policy or program covering the insured person as a dependent are determined before those of the policy or program covering that insured person as other than a dependent.
- 3) Except as stated in paragraph (4), when this Program and another policy or program cover the same child as a dependent of different persons, called parents:
  - a) The benefits of the policy or program of the parent whose birthday falls earlier in a year are determined before those of the policy or program of the parent whose birthday falls later in that year; but
  - b) If both parents have the same birthday, the benefits of the policy or program covering one parent longer are determined before those of the policy or program covering the other parent for a shorter period of time.
  - c) However, if the other policy or program does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the policies or programs do not agree on the order of benefits, the rule in the other policy or program determines the order of benefits.
- 4) Unless there is a court decree stating otherwise, in the case of a dependent child of legally separated or divorced parents, or parents who are not living together, whether or not they have ever been married, the order of benefits for the child is as follows: (1) the policy or program covering the Enrollee as a dependent of the parent with legal custody; (2) as a dependent of the custodial parent's spouse (i.e. step-parent); (3) the policy or program covering the Enrollee as a dependent of the parent without legal custody; and then (4) the policy or program covering the non-custodial parent's spouse.

- 5) If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a policy or program covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy or program covering the child as a dependent child.
- 6) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (3) shall determine the order of benefits.
- 7) 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 health care expenses of the child, the policies or programs covering the child will follow the order of benefit determination rules outlined in paragraph (3).
- 8) For a dependent child who has coverage under either or both parents' policies or programs and also has his or her own coverage as a dependent under a spouse's policy or program, the policy or program that covered the person for the longer period of time is the primary policy or program and the policy or program that covered the person for the shorter period of time is the secondary policy or program. In the event the dependent child's coverage under the spouse's policy or program began on the same date as the dependent child's coverage under either or both parents' policies or programs, the order of benefits shall be determined by applying the birthday rule in paragraph (3) to the dependent child's parent(s) and the dependent's spouse.
- 9) The benefits of a policy or program covering an insured person as an employee who is neither laid-off nor retired are determined before those of a policy or program covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other policy or program does not have this rule, and if, as a result, the policies or programs do not agree on the order of benefits, this rule (9) is ignored.
- 10) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another policy or program, the following will be the order of benefit determination.
  - a) First, the benefits of a policy or program covering the insured person as an employee (or as that insured person's dependent).
  - b) Second, the benefits under the continuation coverage.
  - c) If the other policy or program does not have the rule described above, and if, as a result, the policies or programs do not agree on the order of benefits, this rule (10) is ignored.

- 11) If the primary policy or program cannot be determined by the proceeding rules, the policy or program which has covered the Enrollee for a longer period of time shall be primary and the policy or program that covered the Enrollee for the shorter period of time is the secondary plan.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses.

“Allowable Expense” is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

The difference between the Benefit payments that this plan would have paid had it been the primary plan, and the Benefit payments that it actually paid or provided shall be recorded as a Benefit reserve for the covered person and used by this plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

- 1) determine its obligation to pay or provide Benefits under its Contract;
- 2) determine whether a Benefit reserve has been recorded for the covered person, and
- 3) determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a Benefit reserve, the secondary plan will use the covered person's Benefit reserve to pay up to 100% of the total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the Benefit reserve returns to zero. A new Benefit reserve must be created for each new claim determination period.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

An Enrollee shall provide to the Administrator, and the Administrator may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. The Administrator will, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement will be deemed to be Benefits under this Program. The Administrator will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as it chooses, the amount of any Benefits paid by the Administrator which exceeds its obligations under these coordination of benefit provisions.

## **Appeal Procedure**

The following contains important information about how to file an Appeal. If you are dissatisfied with our benefit determination on a claim, you may Appeal our decision by following the steps outlined in this procedure. We will resolve your Appeal in a thorough, appropriate and timely manner. You, your Authorized Representative or your Health Care Provider may submit written comments, documents, records and other information relating to claims or Appeals. You may call the Customer Service Department at 844-697-0578 or write to us at P.O. Box 1860, Alpharetta, GA 30023. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by us required under these procedures will be supplied to you, your Authorized Representative or your Health Care Provider.

## **Definitions**

The following terms when used in this procedure have the meanings shown below.

“Appeal” is a protest filed by you, your Authorized Representative or a Health Care Provider with us under our internal appeal process regarding a Coverage Decision.

“Appeal Decision” is a final determination by us that arises from an Appeal filed with us under our Appeal procedure regarding a Coverage Decision.

“Authorized Representative” is a person granted authority to act on your behalf regarding a claim for benefit or an Appeal of a Coverage Decision. An assignment of benefits is not a grant of authority to act on your behalf in pursuing a Coverage Decision.

“Claim for Benefits” is a request for a plan benefit or benefits by you in accordance with the Plan’s reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

“Compelling Reason” means that a delay in receiving health care service could result in: loss of life; serious impairment to a bodily function; serious dysfunction of a bodily organ; the Enrollee remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Enrollee to be in danger to self or others; or the Enrollee continuing to experience severe withdrawal symptoms.

“Complaint” is a protest filed with the Commissioner involving a Coverage Decision.

“Coverage Decision” is:

- 1) The initial determination by us resulting in non-coverage of a dental care service.
- 2) The determination by us that you are not eligible for coverage.
- 3) A determination by us that results in a rescission of coverage.

The Company does not make utilization review determinations based on dental necessity or appropriateness. A Coverage Decision is not an adverse decision.

“Health Care Provider” is an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practices of a profession and is a treating provider of the Enrollee or a Hospital.

“Hospital” means an institution that: has a group of at least five (5) physicians who are organized as a medical staff for the institution; maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two (2) or more unrelated individuals; and admits or retains the individuals for overnight care.

“Pre-service Claim” is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

“Post-service Claim” (“Claim”) is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

## **Procedure for Pre-Service Claim**

You, your Health Care Provider or your Authorized Representative have 180 days from the date you or your Authorized Representative received notice of the Coverage Decision to appeal the decision. To file an appeal, you may call the Customer Service Department at 844-697-0578 or the appeal may be addressed in writing to:

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

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide you, your Health Care Provider or your Authorized Representative with written or electronic notice of our Coverage Decision within 30 days after a Coverage Decision has been made. The notice of our Coverage Decision will include the following:

- a) The specific factual basis for our decision in detailed and clear understandable language;
- b) A reference to specific plan provisions on which the decision was based;
- c) A statement that you, your Health Care Provider or your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge;

- d) A statement of your, your Health Care Provider's or your Authorized Representative's right to bring a civil action under ERISA;
- e) A statement that you, your Health Care Provider or your Authorized Representative has a right to file an Appeal with us. Our internal appeal process must be exhausted before you may file a Complaint with the Commissioner of Insurance;
- f) A statement that you, your Health Care Provider or your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

**Commissioner  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202  
Phone: 410-468-2000 or 800-492-6116  
Fax: 410-468-2270**

- g) A statement that the Health Advocacy Unit is available to assist you in both mediating and filing an Appeal under our internal appeal process. You may contact the Health Advocacy Unit at:

**Maryland Office of the Attorney General  
Health Education and Advocacy Unit  
200 St. Paul Place, 16th Floor  
Baltimore, MD 21202  
Phone: 410-528-1840 or toll-free: 877-261-8807  
Fax: 410-576-6571  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)  
Website: <http://www.oag.state.md.us>**

## **Procedure for Post-Service Claim**

You, your Health Care Provider or your Authorized Representative may file an Appeal with us upon the receipt of a Coverage Decision. To file an appeal, you may call the Customer Service Department at 844-697-0578 or the appeal may be addressed in writing to:

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

We will review the claim and notify you of our decision within thirty (30) working days of the request for an Appeal. Within thirty (30) calendar days after a Coverage Decision has been made, we will send a written notice of the Coverage Decision to you or your Authorized Representative and the treating provider.



The notice of Coverage Decision from us shall include:

- 1) The specific factual basis for our decision in detailed and clear, understandable language.
- 2) A statement that you, your Health Care Provider or your Authorized Representative has a right to file an Appeal with us. Our internal appeal process must be exhausted before you may file a Complaint with the Commissioner of Insurance.
- 3) A statement that you, your Health Care Provider or your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

**Commissioner  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202  
Phone: 410-468-2000 or 800-492-6116  
Fax: 410-468-2270**

- 4) A statement that the Health Advocacy Unit is available to assist you in both mediating and filing an Appeal under our internal appeal process. You may contact the Health Advocacy Unit at:

**Maryland Office of the Attorney General  
Health Education and Advocacy Unit  
200 St. Paul Place, 16th Floor  
Baltimore, MD 21202  
Phone: 410-528-1840 or toll-free: 877-261-8807  
Fax: 410-576-6571  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)  
Website: <http://www.oag.state.md.us>**

## **Appeals Procedure**

You may request reconsideration of a Coverage Decision by submitting a written Appeal to us. We will reconsider the Coverage Decision. The Appeal will be reviewed and a final decision rendered. The final decision will be in writing to you or your Authorized Representative and the Health Care Provider within sixty (60) working days after the date on which the Appeal is filed.

The final decision will include a written notice of the Appeal decision. Written notice of the Appeal decision will be sent within thirty (30) calendar days of

the Appeal decision to you or your Authorized Representative and the Health Care Provider acting on your behalf. The notice of the Appeal decision shall include the following:

- a) The specific factual basis for our decision in detailed and clear, understandable language.
- b) That you, your Health Care Provider or your Authorized Representative has a right to file a Complaint with the Commissioner within four (4) months after receipt of our Appeal decision, including the contact information as indicated above. The Commissioner's address is as follows:

**Commissioner  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202  
Phone: 410-468-2000 or 800-492-6116  
Fax: 410-468-2270**

- c) A statement that the Health Advocacy Unit is available to assist you in filing a complaint with the Commissioner. You may contact the Health Advocacy Unit at:

**Maryland Office of the Attorney General  
Health Education and Advocacy Unit  
200 St. Paul Place, 16th Floor  
Baltimore, MD 21202  
Phone: 410-528-1840 or toll-free: 877-261-8807  
Fax: 410-576-6571  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)  
Website: <http://www.oag.state.md.us>**

## **Issues other than Coverage Decisions**

For issues such as Complaints about your dental office, enrollment issues or the general operation of the Plan, please contact the Maryland Insurance Administration at the address and telephone number listed above.

## **Renewal and Termination of Benefits**

All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program or such person's enrollment is canceled under the terms of this Program. Delta Dental is not obligated to continue to provide Benefits to any such person in such event except for the following situations:

Delta Dental will continue to provide Benefits for treatment in progress (less any applicable Copayment) if the treatment:

- 1) began before the date coverage terminates; and

- 2) requires two or more visits on separate days to the assigned Contract Dentist's facility.

Benefits will cease 90 days after termination of coverage.

If you or your dependents are receiving orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

- 1) 60 days if you are making monthly payments to your Contract Orthodontist; or
- 2) until the later of 60 days or the end of the quarter in progress, if you are making quarterly payments to your Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall increase to a maximum of the Contract Orthodontist's usual fee for Enrollees and covered dependents to age 19 and the Contract Orthodontist's usual fee for Enrollees and covered dependents over age 19.

The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

If a Contract Dentist or Contract Orthodontist is aware that this Program has terminated, the Contract Dentist or Contract Orthodontist shall inform any previously enrolled persons who visit his/her dental office of the termination and of all charges for scheduled dental services before they are performed.

## **Cancellation of Enrollment**

Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

- 1) immediately:
  - a) upon loss of eligibility as described in this Evidence of Coverage; or
  - b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
- 2) upon 15 days written notice if:
  - a) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
- 3) upon 30 days written notice if:
  - a) the Contract is terminated or not renewed;
  - b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

- c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. The Administrator must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist.

If the Enrollee establishes a history of unsatisfactory relationships, the Administrator will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. The Administrator will also specify the changes that are necessary in order to avoid cancellation and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

## **Contestability**

The Contract may not be contested by Delta Dental, except for nonpayment of premiums, after it has been in force for 2 years from the effective date. Absent fraud, each statement made by an applicant, group contract holder or Enrollee is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce Benefits under the Contract unless: 1) the statement is contained in a written instrument signed by the group contract holder or Enrollee, and 2) a copy of the statement is given to the group contract holder or Enrollee.

## **Legal Actions**

An action at law or in equity may not be brought to recover on the Contract before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Contract or after the expiration of 3 years after the written proof of loss is required to be furnished.

## **Optional Continuation of Coverage**

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

## **DEFINITIONS**

The meaning of key terms used in this section is shown below.

**Qualified Beneficiary** means:

- 1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event; or

- 2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 60 days of birth or placement for adoption.

**Qualifying Event** means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

- Event 1. the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
- Event 2. your death;
- Event 3. your divorce or legal separation from your spouse;
- Event 4. your dependent's loss of dependent status under the plan; and
- Event 5. as to your dependents only, your entitlement to Medicare.

**You or your** means the Primary Enrollee.

#### PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18 month period can be extended for a total of 29 months, provided:

- 1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
- 2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event.

If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

## ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

## CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

## TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

- 1) the allowable number of consecutive months of continued coverage is reached;
- 2) failure to pay the required premiums in a timely manner;
- 3) the employer ceases to provide any group dental plan to its employees;
- 4) the individual moves out of the plan's service area;

- 5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
- 6) entitlement to Medicare.

The employer shall notify Delta Dental within 60 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

#### TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 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 employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

#### OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

# SCHEDULE A

## Description of Benefits and Copayments

The benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of benefits.

**Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

**Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology (“CDT”), CDT-2020, 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>ENROLLEE PAYS</u>
<b>D0100-D0999 I. DIAGNOSTIC</b>		
D0120	Periodic oral evaluation - established patient .....	\$0.00
D0140	Limited oral evaluation - problem focused .....	\$0.00
D0145	Oral evaluation for a patient under three years of age.....	\$0.00
D0150	Comprehensive oral evaluation - new or established patient.....	\$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).....	\$0.00
D0171	Re-evaluation - post-operative office visit .....	\$0.00
D0180	Comprehensive periodontal evaluation - new or established patient.....	\$0.00
D0190	Screening of a patient.....	\$0.00
D0191	Assessment of a patient.....	\$0.00
D0210	Intra-oral - complete series - <i>limited to 1 series per 3-year period</i> .....	\$0.00
D0220	Intraoral - periapical first radiographic image.....	\$0.00
D0230	Intraoral - periapical each additional radiographic image ...	\$0.00
D0240	Intraoral - occlusal radiographic image .....	\$0.00
D0270	Bitewing - single radiographic image .....	\$0.00
D0272	Bitewings - two radiographic images .....	\$0.00
D0273	Bitewings three radiographic images.....	\$0.00
D0274	Bitewings - four radiographic images - <i>limited to 1 series per 6 consecutive months through age 13, and one series per 12 consecutive months for age 14 and older</i> ....	\$0.00
D0277	Vertical bitewings - 7 to 8 radiographic images.....	\$0.00



D0330	Panoramic radiographic image - <i>limited to 1 per 3-year period</i> .....	\$0.00
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis.....	\$0.00
D4019	Assessment of salivary flow by measurement.....	\$0.00
D0460	Pulp vitality tests.....	\$0.00
D0470	Diagnostic casts.....	\$0.00
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 3 years</i> .....	\$0.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 3 years</i> .....	\$0.00
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 3 years</i> .....	\$0.00
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> .....	\$0.00

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

- *One additional Prophylaxis in a twelve consecutive month period for Members under the care of a medical professional for pregnancy. Member Copayments on the Schedule of Benefits shall apply.*

- *Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.*

D1110	Prophylaxis cleaning - adult - 2 D1110, D1120 or D4346 per plan year.....	\$0.00
D1120	Prophylaxis cleaning - child - 2 D1110, D1120 or D4346 per plan year.....	\$0.00
D1206	Topical fluoride varnish - 2 per plan year; through age 18.....	\$0.00
D1208	Topical application of fluoride - excluding varnish - 2 per plan year; through age 18.....	\$0.00
D1330	Oral hygiene instructions.....	\$0.00
D1351	Sealant - <i>limited to permanent first and second molars through age 15; 1 per tooth per three years</i> .....	\$0.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i> .....	\$0.00
D1353	Sealant repair - per tooth - <i>limited to permanent first and second molars through age 15; 1 per tooth per two years</i> ..	\$0.00
D1354	Interim caries arresting medicament application - per tooth - 2 per plan year; through age 18.....	\$0.00
D1510	Space maintainer - fixed - unilateral – per quadrant - through age 18.....	\$0.00
D1516	Space maintainer - fixed - bilateral, maxillary - through age 18.....	\$0.00

D1517	Space maintainer - fixed - bilateral, mandibular - <i>through age 18</i> .....	\$0.00
D1520	Space maintainer - removable - unilateral – per quadrant - <i>through age 18</i> .....	\$0.00
D1556	Removal of fixed unilateral space maintainer – per quadrant.....	\$0.00
D1557	Removal of fixed bilateral space maintainer – maxillary.....	\$0.00
D1558	Removal of fixed bilateral space maintainer – mandibular.....	\$0.00
D1575	Distal shoe space maintainer - fixed - unilateral– per quadrant - <i>child to age 9</i> .....	\$0.00

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

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
- *Replacement of crowns, inlays, onlays, buildups, post and cores requires the existing restoration to be 5+ years old.*

D2140	Amalgam - one surface, primary or permanent .....	\$0.00
D2150	Amalgam - two surfaces, primary or permanent.....	\$0.00
D2160	Amalgam - three surfaces, primary or permanent .....	\$0.00
D2161	Amalgam - four or more surfaces, primary or permanent...	\$0.00
D2330	Resin-based composite - one surface, anterior .....	\$0.00
D2331	Resin-based composite - two surfaces, anterior.....	\$0.00
D2332	Resin-based composite - three surfaces, anterior .....	\$0.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).....	\$70.00
D2391	Resin-based composite - one surface, posterior .....	\$40.00
D2392	Resin-based composite - two surfaces, posterior .....	\$60.00
D2393	Resin-based composite - three surfaces, posterior .....	\$72.00
D2394	Resin-based composite - four or more surfaces, posterior .....	\$84.00
D2510	Inlay - metallic - one surface .....	\$60.00
D2520	Inlay - metallic - two surfaces.....	\$100.00
D2530	Inlay - metallic - three or more surfaces.....	\$120.00
D2542	Onlay - metallic - two surfaces.....	\$20.00
D2543	Onlay - metallic - three surfaces .....	\$30.00
D2544	Onlay - metallic - four or more surfaces.....	\$50.00
D2710	Crown - resin-based composite (indirect) .....	\$77.00
D2712	Crown - 3/4 resin-based composite (indirect) .....	\$86.00
D2740	Crown - porcelain/ceramic .....	\$270.00
D2750	Crown - porcelain fused to high noble metal.....	\$276.00
D2751	Crown - porcelain fused to predominantly base metal....	\$258.00
D2752	Crown - porcelain fused to noble metal .....	\$270.00
D2753	Crown - porcelain fused to titanium or titanium alloy .....	\$276.00
D2780	Crown - 3/4 cast high noble metal .....	\$228.00
D2781	Crown - 3/4 cast predominantly base metal.....	\$228.00
D2782	Crown - 3/4 cast noble metal .....	\$228.00

D2783	Crown - 3/4 porcelain/ceramic .....	\$228.00
D2790	Crown - full cast high noble metal.....	\$228.00
D2791	Crown - full cast predominantly base metal.....	\$258.00
D2792	Crown - full cast noble metal.....	\$264.00
D2794	Crown - titanium and titanium alloy.....	\$290.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restorations .....	\$15.00
D2920	Re-cement or re-bond crown .....	\$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp ( <i>anterior</i> ).....	\$70.00
D2930	Prefabricated stainless steel crown - primary tooth - <i>anterior primary tooth</i> .....	\$48.00
D2931	Prefabricated stainless steel crown - permanent tooth....	\$56.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.....	\$48.00
D2940	Protective restoration.....	\$0.00
D2941	Interim therapeutic restoration - primary dentition .....	\$0.00
D2949	Restorative foundation for an indirect restoration .....	\$100.00
D2950	Core buildup, including any pins when required .....	\$100.00
D2951	Pin retention - per tooth, in addition to restoration.....	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> .....	\$108.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> .....	\$45.00
D2954	Prefabricated post and core in addition to crown - <i>includes canal preparation</i> .....	\$108.00
D2957	Each additional prefabricated post - same tooth - <i>includes canal preparation</i> .....	\$45.00
D2971	Additional procedures to construct new crown under existing partial denture framework.....	\$25.00

**D3000-D3999 IV. ENDODONTICS *When referable services are provided by a Participating Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's usual fee.\****

D3110	Pulp cap - direct (excluding final restoration).....	\$0.00
D3120	Pulp cap - indirect (excluding final restoration).....	\$0.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.....	\$25.00
D3221	Pulpal debridement, primary and permanent teeth.....	\$15.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .....	\$25.00

D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - <i>through age five on primary anterior teeth and through age 11 on primary posterior teeth</i> .....	\$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) - <i>through age five on primary anterior teeth and through age 11 on primary posterior teeth</i> .....	\$55.00
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration) - <i>one per tooth per lifetime</i> ..	\$108.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration) - <i>one per tooth per lifetime</i> ..	\$144.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration) - <i>one per tooth per lifetime</i> ..	\$198.00
D3346	Retreatment of previous root canal therapy - anterior - <i>one per tooth per lifetime</i> .....	\$198.00
D3347	Retreatment of previous root canal therapy - premolar - <i>one per tooth per lifetime</i> .....	\$234.00
D3348	Retreatment of previous root canal therapy - molar - <i>one per tooth per lifetime</i> .....	\$288.00
D3410	Apicoectomy - anterior .....	\$107.00
D3421	Apicoectomy - premolar (first root).....	\$107.00
D3425	Apicoectomy - molar (first root).....	\$107.00
D3426	Apicoectomy (each additional root).....	\$41.00
D3427	Periradicular surgery without apicoectomy .....	\$107.00
D3450	Root amputation - per root.....	\$50.00
D3920	Hemisection (including any root removal), not including root canal therapy .....	\$41.00

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

- *Surgical periodontal procedures - one per 24 consecutive month period per area of the mouth.*

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.....	\$125.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.....	\$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.....	\$0.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.....	\$135.00

D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$54.00
D4245	Apically positioned flap .....	\$110.00
D4249	Clinical crown lengthening - hard tissue - <i>one per tooth per lifetime</i> .....	\$105.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.....	\$210.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	\$110.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant.....	\$115.00
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.....	\$100.00
D4276	Combined connective tissue and double pedicle graft, per tooth.....	\$100.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.....	\$100.00
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 .....	\$100.00
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.....	\$60.00
D4320	Provisional splinting - intracoronal .....	\$40.00
D4321	Provisional splinting - extracoronal .....	\$40.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	\$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	\$16.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>2 D1110, D1120 or D4346 per plan year</i> .....	\$0.00

D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> .....	\$50.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth .....	\$100.00
D4910	Periodontal maintenance - <i>limited to 2 treatments per plan year</i> .....	\$30.00
D4921	Gingival irrigation - per quadrant.....	\$0.00

**D5000-D5899 VI. PROSTHODONTICS (removable)**

- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*
- *Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

D5110	Complete denture - maxillary .....	\$264.00
D5120	Complete denture - mandibular .....	\$264.00
D5130	Immediate denture - maxillary.....	\$288.00
D5140	Immediate denture - mandibular .....	\$288.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$174.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$174.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth) .....	\$270.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth) .....	\$270.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth).....	\$174.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth).....	\$174.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth) .....	\$270.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth) .....	\$270.00

D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).....	\$350.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).....	\$350.00
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary .....	\$78.00
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular.....	\$78.00
D5410	Adjust complete denture - maxillary.....	\$7.00
D5411	Adjust complete denture - mandibular .....	\$7.00
D5421	Adjust partial denture - maxillary.....	\$7.00
D5422	Adjust partial denture - mandibular .....	\$7.00
D5511	Repair broken complete denture base, mandibular.....	\$21.00
D5512	Repair broken complete denture base, maxillary.....	\$21.00
D5520	Replace missing or broken teeth - complete denture (each tooth).....	\$28.00
D5611	Repair resin partial denture base, mandibular.....	\$23.00
D5612	Repair resin partial denture base, maxillary.....	\$23.00
D5621	Repair cast partial framework, mandibular .....	\$33.00
D5622	Repair cast partial framework, maxillary .....	\$33.00
D5630	Repair or replace broken retentive/clasping materials - per tooth.....	\$23.00
D5640	Replace broken teeth - per tooth .....	\$18.00
D5650	Add tooth to existing partial denture .....	\$23.00
D5660	Add clasp to existing partial denture - per tooth.....	\$33.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).....	\$147.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).....	\$147.00
D5710	Rebase complete maxillary denture.....	\$55.00
D5711	Rebase complete mandibular denture.....	\$55.00
D5720	Rebase maxillary partial denture .....	\$48.00
D5721	Rebase mandibular partial denture.....	\$48.00
D5730	Reline complete maxillary denture (chairside).....	\$40.00
D5731	Reline complete mandibular denture (chairside) .....	\$40.00
D5740	Reline maxillary partial denture (chairside).....	\$40.00
D5741	Reline mandibular partial denture (chairside).....	\$40.00
D5750	Reline complete maxillary denture (laboratory) .....	\$55.00
D5751	Reline complete mandibular denture (laboratory).....	\$55.00
D5760	Reline maxillary partial denture (laboratory) .....	\$55.00
D5761	Reline mandibular partial denture (laboratory).....	\$55.00
D5810	Interim complete denture (maxillary).....	\$125.00
D5811	Interim complete denture (mandibular).....	\$125.00
D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i> .....	\$105.00

D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i> .....	\$105.00
D5850	Tissue conditioning, maxillary .....	\$25.00
D5851	Tissue conditioning, mandibular .....	\$25.00

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

**D6000-D6199 VIII. IMPLANT SERVICES**

- *Replacement of a crown, fixed denture or retainer requires the existing unit to be 5+ years old.*

D6010	Surgical placement of implant body: endosteal implant.....	\$1,983.00
D6011	Second stage implant surgery .....	\$0.00
D6013	Surgical placement of mini implant .....	\$991.50
D6040	Surgical placement: epostal implant .....	\$1,983.00
D6050	Surgical placement: transosteal implant .....	\$1,783.00
D6058	Abutment supported porcelain/ceramic crown.....	\$1,030.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal) .....	\$1,030.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal) .....	\$970.00
D6061	Abutment supported porcelain fused to metal crown (noble metal) .....	\$985.00
D6062	Abutment supported cast metal crown (high noble metal) .....	\$1,036.00
D6063	Abutment supported cast metal crown (predominantly base metal) .....	\$925.00
D6064	Abutment supported cast metal crown (noble metal).....	\$985.00
D6065	Implant supported porcelain/ceramic crown .....	\$1,030.00
D6066	Implant supported porcelain fused to metal crown (or high noble metal) .....	\$1,030.00
D6067	Implant supported metal crown (high noble metal) .....	\$1,036.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.....	\$54.00
D6082	Implant supported crown – porcelain fused to predominantly base alloys .....	\$970.00
D6083	Implant supported crown – porcelain fused to noble alloys .....	\$985.00
D6084	Implant supported crown – porcelain fused to titanium and titanium alloy .....	\$987.00
D6085	Provisional implant crown .....	\$0.00
D6086	Implant supported crown – predominantly base alloys...	\$925.00
D6087	Implant supported crown – noble alloys.....	\$985.00



D6088	implant supported crown - titanium/titanium alloys .....	\$987.00
D6092	Re-cement or re-bond implant/abutment supported crown .....	\$66.00
D6094	Abutment supported crown (titanium).....	\$987.00
D6095	Repair implant abutment, by report.....	\$166.00
D6096	Remove broken implant retaining screw.....	\$66.00
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys.....	\$987.00
D6100	Implant removal, by report .....	\$172.00
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 .....	\$54.00
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 .....	\$110.00
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.....	\$115.00
D6104	Bone graft at time of implant placement .....	\$115.00

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

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

D6205	Pontic - indirect resin based composite .....	\$290.00
D6210	Pontic - cast high noble metal.....	\$276.00
D6211	Pontic - cast predominantly base metal .....	\$258.00
D6212	Pontic - cast noble metal.....	\$264.00
D6214	Pontic - titanium and titanium alloys .....	\$297.00
D6240	Pontic - porcelain fused to high noble metal.....	\$276.00
D6241	Pontic - porcelain fused to predominantly base metal ....	\$258.00
D6242	Pontic - porcelain fused to noble metal.....	\$264.00
D6243	Pontic - porcelain fused to titanium or titanium alloys.....	\$264.00
D6245	Pontic - porcelain/ceramic.....	\$258.00
D6610	Retainer onlay - cast high noble metal, two surfaces .....	\$150.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces.....	\$100.00
D6614	Retainer onlay - cast noble metal, two surfaces .....	\$125.00
D6710	Retainer crown - indirect resin based composite .....	\$290.00
D6740	Retainer crown - porcelain/ceramic .....	\$258.00
D6750	Retainer crown - porcelain fused to high noble metal.....	\$276.00

D6751	Retainer crown - porcelain fused to predominantly base metal .....	\$258.00
D6752	Retainer crown - porcelain fused to noble metal.....	\$264.00
D6753	Retainer crown - porcelain fused to titanium or titanium alloys .....	\$276.00
D6784	Retainer crown $\frac{3}{4}$ – titanium and titanium alloys .....	\$276.00
D6790	Retainer crown - full cast high noble metal.....	\$276.00
D6791	Retainer crown - full cast predominantly base metal .....	\$258.00
D6792	Retainer crown - full cast noble metal.....	\$264.00
D6794	Retainer crown - titanium and titanium alloys .....	\$290.00
D6930	Re-cement or re-bond fixed partial denture .....	\$17.00

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

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

- *Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm., frenectomy and crown lengthening.*

D7111	Extraction, coronal remnants - primary tooth.....	\$8.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .....	\$20.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.....	\$27.00
D7220	Removal of impacted tooth - soft tissue.....	\$45.00
D7230	Removal of impacted tooth - partially bony.....	\$55.00
D7240	Removal of impacted tooth - completely bony.....	\$65.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	\$80.00
D7250	Removal of residual tooth roots (cutting procedure).....	\$35.00
D7251	Coronectomy - intentional partial tooth removal .....	\$65.00
D7280	Exposure of an unerupted tooth.....	\$52.00
D7283	Placement of device to facilitate eruption of impacted tooth .....	\$13.00
D7285	Incisional biopsy of oral tissue - hard - <i>does not include pathology laboratory procedures</i> .....	\$35.00
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....	\$28.00
D7288	Brush biopsy - transepithelial sample collection .....	\$45.00
D7310	Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	\$23.00
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	\$30.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.....	\$30.00

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.....	\$60.00
D7471	Removal of lateral exostosis (maxilla or mandible).....	\$60.00
D7472	Removal of torus palatinus .....	\$60.00
D7473	Removal of torus mandibularis .....	\$60.00
D7485	Reduction of osseous tuberosity.....	\$60.00
D7510	Incision and drainage of abscess - intraoral soft tissue ...	\$35.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site .....	\$0.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure.....	\$53.00
D7963	Frenuloplasty .....	\$27.00
D7972	Surgical reduction of fibrous tuberosity.....	\$60.00

**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.*
- *Comprehensive orthodontic treatment plan - one per lifetime.*

*Pre and post orthodontic records include:*

*The benefit for pre-treatment records and diagnostic services includes:.....*\$150.00

D0210	Intraoral - complete series of radiographic images
D0322	Tomographic survey
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0350	2D oral/facial photographic image obtained intraorally or extra-orally
D0351	3D photographic image
D0470	Diagnostic casts

*The benefit for post-treatment records includes: .....*\$100.00

D0210	Intraoral - complete series of radiographic images
D0470	Diagnostic casts

D8010	Limited orthodontic treatment of the primary dentition....	\$380.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$405.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$430.00

D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$455.00
D8050	Interceptive orthodontic treatment of the primary dentition .....	\$650.00
D8060	Interceptive orthodontic treatment of the transitional dentition .....	\$750.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ....	\$1,800.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$1,950.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$2,200.00
D8210	Removable appliance therapy .....	\$390.00
D8220	Fixed appliance therapy.....	\$370.00
D8660	Pre-orthodontic treatment examination to monitor growth and development.....	\$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers).....	\$150.00
D8681	Removable orthodontic retainer adjustment .....	\$0.00
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> .....	\$0.00

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

D9110	Palliative (emergency) treatment of dental pain - minor procedure.....	\$15.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures.....	\$20.00
D9211	Regional block anesthesia .....	\$26.00
D9212	Trigeminal division block anesthesia .....	\$15.00
D9215	Local anesthesia in conjunction with operative or surgical procedures.....	\$18.00
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia.....	\$0.00
D9222	Deep sedation/general anesthesia - first 15 minutes.....	\$103.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment.....	\$103.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes .....	\$100.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.....	\$100.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician ....	\$20.00
D9311	Consultation with medical health care professional.....	\$0.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.....	\$0.00

D9440	Office visit - after regularly scheduled hours.....	\$30.00
D9630	Drugs or medicaments dispensed in the office for home use .....	\$20.00
D9932	Cleaning and inspection of removable complete denture, maxillary.....	\$0.00
D9933	Cleaning and inspection of removable complete denture, mandibular .....	\$0.00
D9934	Cleaning and inspection of removable partial denture, maxillary.....	\$0.00
D9935	Cleaning and inspection of removable partial denture, mandibular .....	\$0.00
D9951	Occlusal adjustment, limited .....	\$20.00
D9952	Occlusal adjustment, complete .....	\$45.00
D9990	Certified translation or sign-language services - per visit.....	\$0.00
D9991	Dental case management - addressing appointment compliance barriers.....	\$0.00
D9992	Dental case management - care coordination .....	\$0.00
D9995	Teledentistry - synchronous; real-time encounter .....	\$0.00
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review .....	\$0.00
D9997	Dental case management – Patients with special Health Care Needs .....	\$0.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by the Administrator. The Enrollee pays the Copayment specified for such services.

DeltaCare USA is underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

# SCHEDULE B

## Limitations and Exclusions of Benefits

### Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. Administration of I.V. sedation or general anesthesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more soft tissue, partial or full bony impactions, (Procedures D7220, D7230, D7240, and D7241).
3. Benefits provided by a contract pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:
  - a. If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:
  - b. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist, or
  - c. until the later of 60 days or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

5. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

6. Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. We will make payment based upon the allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of dental treatment. Our decision does not commit You to the less expensive procedure. However, if You and the Dentist choose the more expensive procedure, You are responsible for the additional charges beyond those paid or allowed by the Company.

## Exclusions

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:
  - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - b. is inconsistent with generally accepted standards for dentistry.
3. As determined by the treating provider not acting on behalf of Delta Dental, services solely for cosmetic purposes 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 or required as the result of orthognathic surgery.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost, stolen or damaged appliances including, but not limited to, prosthetic device, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges) or any duplicative device.
6. For replacement of existing dentures that are, or can be made serviceable.
7. For prosthetic reconstruction or other services which require a prosthodontist.
8. For assistance at surgery.
9. Procedures, appliances or restoration solely for the purpose of changing vertical dimension, including but not limited, to full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

10. 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.
11. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include, but are not limited to, such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to that joint.
12. Consultations for non-covered benefits.
13. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
14. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
15. Prescription drugs or nonprescription drugs, home care items, vitamins or dietary supplements.
16. Dental expenses incurred in connection with any dental procedure, except for qualifying acute conditions and serious chronic conditions, started before the Enrollee's eligibility with the DeltaCare USA Program or after the termination date of coverage. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
17. At the request of an Enrollee or an Enrollee's parent, guardian, designee, or health care provider to the Customer Service department at [844-697-0578 ], Delta Dental shall accept a preauthorization from a relinquishing carrier for procedures, treatments, medications or services covered by the benefits offered by Delta Dental for the lesser of the course of treatment or 90 days. In addition, Delta Dental shall allow a new Enrollee to continue to receive services for qualifying acute conditions and serious chronic conditions being rendered by an Out-of-Network Dentist at the time of the Enrollee's transition to Delta Dental. An Enrollee shall be allowed to continue to receive services for these conditions for the lesser of the course of treatment or 90 days. Coverage for these services will be subject to the benefits, limitations and exclusions described in the EOC. The Enrollee will be liable for the same fees and/or Copayments that would be paid to a Contract Dentist for the same treatment. If an Out-of-Network Dentist does not accept Delta Dental's method of compensation nor any allowed alternative, the Out-of-Network Dentist is not required to continue to provide the services.



18. As determined by the treating provider not acting on behalf of Delta Dental, for elective procedures, including prophylactic extractions of third molars.
19. For the following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.
20. Specialist or orthodontic treatment resulting from a prohibited referral. A prohibited referral is when the Contract Dentist directs an Enrollee to seek specialist or orthodontic care from another dental facility where a) the Contract Dentist owns a beneficial interest in the practice; b) the Contract Dentist's immediate family owns a beneficial interest of 3 percent or greater in the practice; or c) the Contract Dentist, the Contract Dentist's immediate family or a combination of the Contract Dentist and his or her immediate family has a compensation arrangement with the practice.
21. For broken appointments.
22. Dental conditions that are the responsibility of Worker's Compensation or employer's liability insurance. The DeltaCare USA benefits would be in excess to the third party benefits and therefore, the Administrator would have the right of recovery for any benefits paid in excess.
23. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the armed forces of any country or international authority.
23. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

DeltaCare USA is underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company

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

Toll Free  
844-697-0578

*Administrator:*  
Delta Dental Insurance Company  
Attn: Customer Service  
P.O. Box 1803  
Alpharetta, GA 30023

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