DELTA DENTAL®

Henrico County
General Government

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Henrico County General Government and Public Schools 2027 dental plans

Delta Dental EPO™

With Delta Dental EPO™ ("EPO Plan"), you will know prior to treatment what you will have to pay for covered benefits. This aids in better financial planning for you and your family. A Delta Dental PPO™ dentist must provide services for covered benefits.

In almost all cases, services rendered by a dentist that is not in the Delta Dental PPO network are not covered. There is one exception.

You may receive covered benefits from a dentist that is not in the Delta Dental PPO network if the covered benefit(s) are emergency services and you are at least 35 miles from a Delta Dental PPO dentist's office. However, your benefit maximum for all emergency services provided by a dentist that is not in the Delta Dental PPO network is limited to $50 per benefit period. Emergency services are covered benefits that require immediate attention to alleviate severe pain, swelling, bleeding or to avoid serious jeopardy to your health.

Delta Dental PPO dentists have agreed to accept Delta Dental's payment and your copayment as payment in full for covered benefits. Refer to the attached Schedule of Benefits and Copayments for more details about what is covered under your plan. Delta Dental PPO dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist.

Please visit **DeltaDentalVA.com** to find a participating dentist in your area. The toll-free phone number for questions about your Delta Dental EPO™ coverage is 800.237.6060.

Delta Dental High and Low Option plans

The High and Low Option plans offered by Delta Dental have an exciting feature that can offer substantial savings. Services are available from dentists in two networks — Delta Dental PPO and Delta Dental Premier®.

Which networks, if any, your dentist is in determines your out-of-pocket costs when you visit the dentist. If your dentist participates in the Delta Dental PPO network, you will be charged less for services than if your dentist participates in the Delta Dental Premier network. If your dentist does not participate in either network, you will still have coverage but will have to pay more of the cost yourself.

To use the plans, just call the dental office of your choice and make an appointment. If you go to a network dentist, he/she will complete and submit claim forms directly to Delta Dental.

If you go to an out-of-network dentist, you are responsible for the dentist's entire bill, and Delta Dental will reimburse you directly unless an assignment of benefits is made to the dentist.

If you visit a Delta Dental PPO network dentist, payment is based on the lowest of:

- the fee the dentist bills Delta Dental
- the most recent fee for the service that the dentist has on file with Delta Dental
- the PPO payment allowance used by the Delta Dental in the state in which the dental service is provided.

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If you visit a Delta Dental Premier network dentist, payment is based on the lowest of:

- the fee the dentist bills Delta Dental
- the most recent fee for the service that the dentist has on file with Delta Dental
- the plan allowance used by the Delta Dental in the state in which the dental service is provided.

If you visit an out-of-network dentist, payment is based on the lowest of:

- the fee the dentist bills Delta Dental
- the plan allowance used by the Delta Dental in the state in which the dental service is provided.

In all cases, Delta Dental determines the plan allowance. Payments for out-of-network dentists' services may be lower than payment allowances for network dentists' services. Delta Dental PPO and Delta Dental Premier dentists have agreed to accept Delta Dental allowances as payment in full for covered benefits. This means that you pay only the deductible and coinsurance for these services.

Advantages of the Delta Dental High and Low Option plans include:

- go to any dentist you wish
- change dentists at any time
- go to a specialist of your choice without pre-approval

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Henrico County General Government and Public Schools
Summary of Plan Benefits
Effective January 1, 2027

Plan features	Delta Dental High and Low option plans						Delta Dental EPO™
	High option			Low option			
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network	
DIAGNOSTIC AND PREVENTIVE CARE/ PREVENTION FIRST • These services are exempt from deductible and calendar year maximum. • Oral exams and cleanings — two/calendar year • Periodontal cleanings- two/calendar year • Fluoride treatment — two/ calendar year (under age 19) • Bitewing X-rays — two/calendar year • Full mouth/panelipse X-rays — one/ five years • Space maintainers — dependents under age 14 • Sealants — only non-carious, non-restored first and second permanent molars (under age 16; limited to one application per tooth every three years) • Healthy Smile, Healthy You® — Enrolled pregnant members and/or enrolled diabetic members are entitled to an additional cleaning or periodontal maintenance visit	100%	100%	80%	75%	75%	75%	100%* Refer to the attached Schedule of Benefits, Copayments and Coinsurance.
BASIC DENTAL CARE • Restorative — amalgam (silver) fillings; composite (white) fillings • Stainless steel crowns — baby/primary teeth only for dependents under age 14 • Oral surgery — simple extractions, impactions and other minor surgical procedures • Endodontics (root canal therapy) — repeat treatment covered only after two years from initial treatment • Periodontics (scaling and root planing, soft tissue and bony surgery, including grafts) —	80%	50%	50%	50%	50%	50%	Fixed Copayment

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limitation of two to three years apply based on services rendered; periodontal cleaning subject to benefit limitation for regular cleaning • Denture repair and recementation of existing crowns, bridges and dentures — cost limited to ½ cost of new denture or prosthesis							
MAJOR DENTAL CARE • Crowns — (single crowns) — once per tooth every five years and only when existing crown cannot be rendered serviceable; benefit available only if the tooth is damaged by decay or fractured to the point it cannot be restored by an amalgam or composite restoration; crowns for dependents under the age of 12 not covered • Prosthodontics (partial or complete dentures and fixed bridges) — once every five years and only when existing prosthesis cannot be rendered serviceable; fixed bridges or removable partials are not benefits for dependents under age 16 • Implants	50%	50%	50%	50%	50%	50%	Fixed Copayment
ORTHODONTICS • These services are exempt from deductible. • For subscribers and covered dependents	50%	50%	50%	NOT COVERED			50%
Lifetime Orthodontic Maximum	$1,500 per patient			NOT COVERED			$2,000/patient
OUT-OF-POCKET EXPENSES	Lowest	Low	Highest	Lowest	Low	Highest	
DENTIST NETWORK	You may use any dentist. Your out-of-pocket expenses will vary based on which, if any, network your Dentist is in.			You may use any dentist. Your out-of-pocket expenses will vary based on which, if any, network your Dentist is in.			A Delta Dental PPO™ dentist must be utilized for care. In almost all cases, services rendered by a dentist that is not in the Delta Dental PPO network are not covered.
CALENDAR YEAR MAXIMUM	$1,500 per patient per calendar year						$3,000/patient
ANNUAL DEDUCTIBLE	$50 per patient per calendar year: $150 per family unit						No annual deductible

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2027 Premiums for Henrico County Public Schools

Employee premium deductions	Delta Dental High Option Plan		
	Full or Part-Time 24 Deductions	Full or Part-Time 19 Deductions	Full or Part-Time 20 Deductions
Employee only	$22.06	$27.87	$26.47
Employee/spouse	$39.90	$50.40	$47.88
Employee/child	$39.90	$50.40	$47.88
Employee/family	$62.65	$79.13	$75.18
Employee premium deductions	**Delta Dental Low Option Plan**		
	Full or Part-Time 24 Deductions	**Full or Part-Time 19 Deductions**	**Full or Part-Time 20 Deductions**
Employee only	$14.79	$18.68	$17.75
Employee/spouse	$26.73	$33.76	$32.08
Employee/child	$26.73	$33.76	$32.08
Employee/family	$41.93	$52.96	$50.32
Employee premium deductions	**Delta Dental EPO™**		
	Full or Part-Time 24 Deductions	**Full or Part-Time 19 Deductions**	**Full or Part-Time 20 Deductions**
Employee only	$13.04	$16.47	$15.64
Employee/spouse	$21.71	$27.42	$26.05
Employee/child	$21.71	$27.42	$26.05
Employee/family	$29.29	$37.00	$35.15

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2027 Premiums for Henrico County General Government

Employee premium deductions	Delta Dental High Option Plan		
	Bi-Weekly	Monthly	Annually
Employee only	$22.06	$44.12	$529.44
Employee/spouse	$39.90	$79.80	$957.60
Employee/child	$39.90	$79.80	$957.60
Employee/family	$62.65	$125.30	$1,503.60
Employee premium deductions	**Delta Dental Low Option Plan**		
	Bi-Weekly	**Monthly**	**Annually**
Employee only	$14.79	$29.58	$354.96
Employee/spouse	$26.73	$53.46	$641.52
Employee/child	$26.73	$53.46	$641.52
Employee/family	$41.93	$83.86	$1,006.32
Employee premium deductions	**Delta Dental EPO™**		
	Bi-Weekly	**Monthly**	**Annually**
Employee only	$13.04	$26.08	$312.96
Employee/spouse	$21.71	$43.41	$520.92
Employee/child	$21.71	$43.41	$520.92
Employee/family	$29.29	$58.58	$702.96

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Questions and answers

Henrico County General Government and Public Schools
Group number 600084

1. **Are there any changes to the Delta Dental plans this year?**
   No, there are no changes to the Delta Dental plan for 2027.

2. **Who needs to enroll?**
   New enrollees or current subscribers who wish to make any changes to their dental coverage. Current subscribers who are not making changes to their coverage do not need to re-enroll.

3. **Is there a choice of dental plans?**
   Yes, there are three plan options. You may choose from the Delta Dental High Option, Delta Dental Low Option, or Delta Dental EPO™ ("EPO Plan"). The "Summary of Plan Benefits" chart will help you make your decision on which dental plan is right for you.

4. **What is the difference between the EPO Plan and the Delta Dental Comprehensive Option plans?**
   With the exception of orthodontic services, the EPO Plan is a fixed copayment plan. Under the EPO Plan, you must visit a Delta Dental PPO dentist for your dental care. This very large network is local, statewide, and national. The EPO Plan allows you to reference your Schedule of Benefits and Copayments to know exactly what you will be paying for Diagnostic and Preventive, Basic and Major services.

5. **What are the differences between the Delta Dental High and Low Option plans?**
   The Delta Dental High and Low Option plans differ in the percentage of your dentist's charges that Delta Dental will pay. Under the High Option, dental services are covered at a higher level than the Low Option. In addition, orthodontics is a covered benefit under the High Option. The Low Option does not cover orthodontics. If you or any of your covered dependents are considering orthodontic treatment you should strongly consider the High Option.

6. **What is the difference between Delta Dental PPO™ Network dentists and Delta Dental Premier® network dentists?**
   There are two types of network dentists under the Delta Dental High and Low Option plans — Delta Dental PPO and Delta Dental Premier dentists. Both networks have agreed to accept Delta Dental's reimbursement allowance. However, you will receive the maximum plan benefits (and pay the lowest out-of-pocket costs) when you obtain services from a Delta Dental PPO dentist. A dentist in either network will file your claim for you and will accept Delta Dental's payment, plus any required employee

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coinsurance and any applicable deductible as payment in full. It is important to determine the network (Delta Dental PPO or Delta Dental Premier) in which your dentist participates so that you can know your out-of-pocket costs.

7. **What will happen if I go to a dentist not in the Delta Dental PPO™ or Delta Dental Premier® networks if I have chosen the High or Low Option plan?**
   Payment is made directly to you and is based on the out-of-network reimbursement schedule. You will be responsible for paying the difference between out-of-network dentists' charges and Delta Dental's payment. You may also have to pay the out-of-network dentists in advance for the entire bill and may have to file the claim with Delta Dental. Benefits are lower when visiting an out-of-network dentist.

8. **How can I find out if my dentist participates with Delta Dental's networks if I have chosen a Delta Dental High or Low Option plan?**
   There are several ways to determine if your dentist participates in Delta Dental's networks:
   - Visit the 'Find A Dentist' section of our website at **DeltaDentalVA.com**.
   - Ask your dentist if they participate in the Delta Dental network. If yes, be sure also to ask whether they participate in both the Delta Dental PPO and Premier networks or the Delta Dental Premier network only.
   - Call Delta Dental's Benefit Services Representatives at 800.237.6060. They are available Monday through Thursday from 8:15 a.m. to 6:00 p.m. EST and Friday from 8:15 a.m. to 4:45 p.m. EST.

9. **How can my dentist enroll in Delta Dental's networks?**
   Ask your dentist to contact the local Delta Dental in your state or have the dentist contact Delta Dental's Professional Relations Department at 855.474.5644.

10. **Will I receive an ID card?**
    All employees who enroll in a Delta Dental plan will receive two new ID cards in the mail. Other ways to access ID cards include:
    - Printing a copy after login to the Members section our website at **DeltaDentalVA.com**.
    - Viewing and emailing from the free Delta Dental mobile app.
    - Calling Delta Dental's Benefit Services Department at 800.237.6060
    - To protect your privacy, Delta Dental ID cards only display the subscriber's name and assigned ID number.

11. **What should I do for my first dental appointment if I have chosen a Delta Dental High or Low Option plan?**
    Present your new ID card or give the dentist your Social Security Number. Tell the dentist your dental plan is administered by Delta Dental of Virginia.

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Claim forms are generally filed directly by the dental offices. Delta Dental will accept any standard ADA approved claim form. Claim forms are available by logging in at **DeltaDentalVA.com** or by calling Delta Dental's Benefit Services Department at 800.237.6060.

12. How can I avoid unexpected charges for dental care if I choose the Delta Dental High or Low Option plan?

- See a dentist who participates in the Delta Dental PPO™ and/or Delta Dental Premier® network.
- Ask your dentist to file a Predetermination/Preauthorization before treatment begins (it is not required but recommended for services over $250).
- Call Delta Dental's Benefit Services Representatives with any benefit clarification questions.

13. What is pre-determination and is it required under Delta Dental's High and Low Option plans?

Pre-determination is a process that helps you find out what your potential costs may be for a particular dental procedure. Your dentist can file a claim for pre-determination of benefits with Delta Dental to determine what your plan will cover and what you may have to pay. Pre-determination is not required but is recommended for any procedures that are expected to cost $250 or more.

14. Will the Delta Dental High and Low Option plans pay for all treatment options for my dental condition?

Not in every situation. If you and your dentist agree on a procedure that is more expensive than the standard ADA recommended service to restore a tooth to contour and function, then Delta Dental will usually pay only the amount for the standard procedure. You would then be responsible for the entire balance of the dentist's fee for the more expensive service.

15. How will Delta Dental pay orthodontia claims for individuals who are currently receiving orthodontia benefits from their previous dental carrier?

If you are a new subscriber in the High Option plan or EPO plan, Delta Dental will calculate the amount the plan would normally pay, then deduct the amount already paid by the previous carrier and complete the normal claim payment process for the duration of orthodontic treatment. Orthodontia is not covered under the Low Option Plan.

16. How can I access my benefit information online?

If you are a subscriber, simply log in to our secure website at **DeltaDentalVA.com** with your username and password. If you are not already registered, click the link for "New user" and follow the instructions to select your username and password. Once you have logged in to our secure website under Subscriber Connection, you will be able to access all your valuable benefits information.

- Print replacement ID cards in the event you lose or misplace your ID card.
- View and/or print the Member Handbook and Evidence of Coverage (EOC).
- Track the status of your dental claims and verify your benefits including benefit design, eligibility, maximum and deductible amounts.

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17. Are there any added benefits available under the Delta Dental High Option, Delta Dental Low Option or EPO program?

Yes, there are additional benefits available to subscribers and their family members enrolled in the Delta Dental High or Low Option Plans only with the exception of Special Health Care Needs; this benefit is available on all plans.

The Healthy Smile, Healthy You® program offers additional benefits for three important health conditions connected to oral health: pregnancy, diabetes and certain high risk cardiac conditions. Members who have one of these conditions may enroll in the program to become eligible for one additional cleaning and exam (or periodontal maintenance procedure if you have a history of periodontal surgery) beyond the ordinary limit per benefit period. It's easy to enroll in the program, simply obtain the one-page enrollment form from Delta Dental's website **DeltaDentalVA.com** or call Delta Dental's Benefit Services Department at 800.237.6060.

Prevention First is another added benefit available to members enrolled in the Delta Dental High or Low Option Plans. With this benefit, visits to the dentist for diagnostic services and preventive care (typically X-rays, exams and cleanings) will no longer count against your calendar year benefit maximum. Instead, you will be rewarded with the entire calendar year benefit maximum amount for other covered services you may need throughout the plan year.

Special Health Care Needs provides additional benefits for members with special needs. To learn more about this benefit visit **DeltaDentalVA.com/special-health-care-needs-resources**.

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Delta Dental High and Low Option plans and Delta Dental EPO™

Examples of payments

Dentist charges below are estimates and used only to illustrate the potential difference in your out-of-pocket costs with each of the three Delta Dental Options and with dentists in different networks. These examples do not include any applicable deductible amounts.

Example 1: Periodic oral evaluation (D0120) and prophylaxis (cleaning) — adult (D1110)

Delta Dental High Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$136.00	$136.00	$136.00
Delta Dental's allowable charges	$80.00	$104.00	$78.00
Plan coverage percentage	100%	100%	80%
Delta Dental's payment	$80.00	$104.00	$62.40
Network savings	$56.00	$32.00	$0.00
Estimated out-of-pocket expenses	$0.00	$0.00	$73.60

Delta Dental Low Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$136.00	$136.00	$136.00
Delta Dental's allowable charges	$80.00	$104.00	$78.00
Plan coverage percentage	75%	75%	75%
Delta Dental's payment	$60.00	$78.00	$58.50
Network savings	$56.00	$32.00	$0.00
Estimated out-of-pocket expenses	$20.00	$26.00	$77.50

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Delta Dental EPO™

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist's charge for covered procedures	$136.00	$136	$136
Delta Dental's plan allowance	$80.00	$0	$0
Patient copayment	$0	N/A	N/A
Delta Dental's payment	$80.00	$0	$0
Patient payment	$0	$0	$0
Amount dentist receives	$80.00	$136	$136

Example 2: Resin-based composite filling, one surface posterior (2391)

Delta Dental High Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$168.00	$168.00	$168.00
Delta Dental's allowable charges	$100.00	$132.00	$96.00
Plan coverage percentage	80%	50%	50%
Delta Dental's payment	$80.00	$66.00	$48.00
Network savings	$68.00	$36.00	$0.00
Estimated out-of-pocket expenses	$20.00	$66.00	$120.00

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Delta Dental Low Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$168.00	$168.00	$168.00
Delta Dental's allowable charges	$100.00	$132.00	$96.00
Plan coverage percentage	50%	50%	50%
Delta Dental's payment	$50.00	$66.00	$48.00
Network savings	$68.00	$36.00	$0.00
Estimated out-of-pocket expenses	$50.00	$66.00	$120.00

Delta Dental EPO™

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist's charge for covered procedures	$168.00	$168.00	$168.00
Delta Dental's plan allowance	$100.00	$0	$0
Patient copayment	$35	N/A	N/A
Delta Dental's payment	$65.00	$0	$0
Patient payment	$35.00	$0	$0
Amount dentist receives	$100.00	$168.00	$168.00

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Example 3: Crown, porcelain fused to high-noble metal (2750)

Delta Dental High Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$1,050.00	$1,050.00	$1,050.00
Delta Dental's allowable charges	$694.00	$882.00	$685.00
Plan coverage percentage	50%	50%	50%
Delta dental's payment	$347.00	$441.00	$342.50
Network savings	$356.00	$168.00	$0.00
Estimated out-of-pocket expenses	$347.00	$441.00	$707.50

Delta Dental Low Option plan

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist charges	$1,050.00	$1,050.00	$1050.00
Delta Dental's allowable charges	$694.00	$882.00	$685.00
Plan coverage percentage	50%	50%	50%
Delta Dental's payment	$347.00	$441.00	$342.50
Network savings	$356.00	$168.00	$0
Estimated out-of-pocket expenses	$347.00	$441.00	$707.50

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Delta Dental EPO™

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network dentist
Dentist's charge for covered procedures	$1,050.00	$1,050.00	$1,050.00
Delta Dental's plan allowance	$694.00	$0	$0
Patient copayment	$405.00	N/A	N/A
Delta Dental's payment	$289.00	$0	$0
Patient payment	$405.00	$0	$0
Amount dentist receives	$694.00	$1,050.00	$1,050.00

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Schedule of Benefits

Delta Dental EPO™ — Henrico (01/2027)

Description of Benefits and Copayment

The benefits shown below are performed as deemed appropriate by the attending Dentist subject to the limitations and exclusions of the program. Refer to the Benefit Limitations and Exclusions for further clarification of benefits. Enrollees should discuss all treatment options with their Dentist prior to services being rendered.

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

CODES		COPAYMENT
I.	**DIAGNOSTIC**	
D0120	Periodic oral evaluation — established patient	No Cost
D0140	Limited oral evaluation — problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation — new or established patient	No Cost
D0160	Detailed and extensive oral evaluation — problem focused, by report	No Cost
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	Not Billable to Patient
D0171	Re-evaluation — post-operative office visit	Not Billable to Patient
D0180	Comprehensive periodontal evaluation — new or established patient	$30.00
D0210	Intraoral — complete series of radiographic images — *limited to 1 series every 24 months*	No Cost
D0220	Intraoral — periapical first radiographic image	No Cost
D0230	Intraoral — periapical each additional radiographic image	No Cost
D0240	Intraoral — occlusal radiographic image	No Cost
D0270	Bitewing — single radiographic image	No Cost
D0272	Bitewings — two radiographic images	No Cost
D0273	Bitewings — three radiographic images	No Cost
D0274	Bitewings — four radiographic images	No Cost
D0277	Vertical bitewings — 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost

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CODES		COPAYMENT
D0387	Intraoral tomosynthesis — comprehensive series of radiographic images — image capture only	Not Billable to Patient
D0388	Intraoral tomosynthesis — bitewing radiographic image — image capture only	Not Billable to Patient
D0389	Intraoral tomosynthesis — periapical radiographic image — image capture only	Not Billable to Patient
D0460	Pulp vitality tests	No Cost
D0461	Testing for cracked tooth	Not Billable to Patient
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0475	Decalcification procedure	Not Billable to Patient
D0476	Special stains for microorganisms	Not Billable to Patient
D0477	Special stains, not for microorganisms	Not Billable to Patient
D0478	Immunohistochemical stains	Not Billable to Patient
D0479	Tissue in-situ hybridization, including interpretation	Not Billable to Patient
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Not Billable to Patient
D0481	Electron microscopy	Not Billable to Patient
D0482	Direct immunofluorescence	Not Billable to Patient
D0483	Indirect immunofluorescence	Not Billable to Patient
D0484	Consultation on slides prepared elsewhere	Not Billable to Patient
D0601	Caries risk assessment and documentation, with a finding of low risk	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk	No Cost
D0701	Panoramic radiographic image — image capture only	Not Billable to Patient

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CODES		COPAYMENT
D0702	2-D cephalometric radiographic image — image capture only	Not Billable to Patient
D0703	2-D oral/facial photographic image obtained intra—orally or extra-orally — image capture only	Not Billable to Patient
D0705	Extra-oral posterior dental radiographic image — image capture only	Not Billable to Patient
D0706	Intraoral — occlusal radiographic image — image capture only	Not Billable to Patient
D0707	Intraoral — periapical radiographic image — image capture only	Not Billable to Patient
D0708	Intraoral — bitewing radiographic image — image capture only	Not Billable to Patient
D0709	Intraoral — complete series of radiographic images — image capture only	Not Billable to Patient
II.	**PREVENTIVE**	
D1110	Prophylaxis *cleaning* — adult — 2 *per 12 month period*	No Cost
D1110	*Additional prophylaxis cleaning — adult (within the 12 month period)*	$41.00
D1120	Prophylaxis *cleaning* — child — 2 *per 12 month period*	No Cost
D1120	*Additional prophylaxis cleaning — child (within the 12 month period)*	$30.00
D1206	Topical application of fluoride varnish — *child to age 19; 1 D1206 or D1208 per 12 month period*	No Cost
D1208	Application of medicament – topical fluoride – excluding varnish; full mouth	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant — per tooth — *limited to permanent molars through age 15*	$10.00
D1510	Space maintainer — fixed, unilateral — per quadrant	$85.00
D1516	Space maintainer — fixed — bilateral — maxillary	$85.00
D1517	Space maintainer — fixed — bilateral — mandibular	$85.00
D1556	Removal of fixed unilateral space maintainer — per quadrant	$10.00
D1557	Removal of fixed bilateral space maintainer — maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer — mandibular	$10.00
D1575	Distal shoe space maintainer — fixed, unilateral — per quadrant	$85.00
III.	**RESTORATIVE (Fillings)**	
	Includes indirect pulp capping, bases, liners and acid etch procedures	
D2140	Amalgam — one surface, primary or permanent	No Cost
D2150	Amalgam — two surfaces, primary or permanent	No Cost
D2160	Amalgam — three surfaces, primary or permanent	No Cost
D2161	Amalgam — four or more surfaces, primary or permanent	No Cost

DELTA DENTAL®

CODES		COPAYMENT
D2330	Resin-based composite — one surface, anterior	No Cost
D2331	Resin-based composite — two surfaces, anterior	No Cost
D2332	Resin-based composite — three surfaces, anterior	No Cost
D2335	Resin-based composite — four or more surfaces (anterior)	$75.00
D2390	Resin-based composite crown – direct	$69.00
D2391	Resin-based composite — one surface — posterior	$35.00
D2392	Resin-based composite — two surfaces — posterior	$45.00
D2393	Resin-based composite — three surfaces — posterior	$65.00
D2394	Resin-based composite — four or more surfaces — posterior	$85.00
D2510	Inlay — metallic — one surface	$360.00
D2520	Inlay — metallic — two surfaces	$360.00
D2530	Inlay — metallic — three or more surfaces	$360.00
D2542	Onlay — metallic — two surfaces	$415.00
D2543	Onlay — metallic — three surfaces	$415.00
D2544	Onlay — metallic — four or more surfaces	$415.00
D2740	Crown — porcelain/ceramic	$445.00
D2750	Crown — porcelain fused to high noble metal	$405.00
D2751	Crown — porcelain fused to predominately base metal	$360.00
D2752	Crown — porcelain fused to noble metal	$385.00
D2780	Crown — ¾ cast high noble metal	$405.00
D2781	Crown — ¾ cast predominately base metal	$360.00
D2782	Crown — ¾ cast noble metal	$385.00
D2790	Crown — full cast high noble metal	$405.00
D2791	Crown — full cast predominately base metal	$360.00
D2792	Crown — full cast noble metal	$385.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$35.00
D2920	Re-cement or re-bond crown	$35.00
D2921	Reattachment of tooth fragment, incisal edge or cusp	$57.00
D2930	Prefabricated stainless steel crown — primary tooth	$95.00
D2931	Prefabricated stainless steel crown — permanent tooth	$95.00
D2932	Prefabricated resin crown — *anterior primary tooth*	$120.00
D2933	Prefabricated stainless steel crown with resin window — *anterior primary tooth*	$150.00
D2940	Placement of interim direct restoration	No Cost
D2950	Core buildup, including any pins when required	$120.00
D2951	Pin retention — per tooth, in addition to restoration	$10.00
D2952	Post and core in addition to crown, indirectly fabricated	$150.00

DELTA DENTAL®

CODES		COPAYMENT
D2954	Prefabricated post and core in addition to crown — *base metal post; includes canal preparation*	$120.00
D2955	Post removal	Not Billable to Patient
D2956	Removal of an indirect restoration on a natural tooth	Not Billable to Patient
D2960	Labial veneer (resin laminate) — chairside	$65.00
D2976	Band stabilization — per tooth	Not Billable to Patient
D2989	Excavation of a tooth resulting in the determination of non-restorability	Not Billable to Patient
IV.	ENDODONTICS	
D3110	Pulp cap — direct (excluding final restoration)	Not Billable to Patient
D3120	Pulp cap — indirect (excluding final restoration)	Not Billable to Patient
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	$50.00
D3221	Pulpal debridement, primary and permanent teeth	$50.00
D3310	*Root canal* — endodontic therapy, anterior tooth (excluding final restoration)	$160.00
D3320	*Root canal* — endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* — endodontic therapy, molar tooth (excluding final restoration)	$255.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy — anterior	$210.00
D3347	Retreatment of previous root canal therapy — premolar	$240.00
D3348	Retreatment of previous root canal therapy — molar	$305.00
D3410	Apicoectomy — anterior	$190.00
D3421	Apicoectomy — premolar (first root)	$190.00
D3425	Apicoectomy — molar (first root)	$190.00
D3426	Apicoectomy (each additional root)	$75.00
D3430	Retrograde filling — per root	$50.00
D3911	Intraorifice barrier	Not Billable to Patient
D3921	Decoronation or submergence of an erupted tooth	$5.00
V.	PERIODONTICS	

DELTA DENTAL®

CODES		COPAYMENT
	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	$120.00
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant	$60.00
D4240	Gingival flap procedure, including root planing — four or more contiguous teeth or tooth bounded spaces, per quadrant	$155.00
D4241	Gingival flap procedure, including root planing — one to three contiguous teeth or tooth bounded spaces, per quadrant	$80.00
D4245	Apically positioned flap	$155.00
D4249	Clinical crown lengthening — hard tissue	$170.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) — four or more contiguous teeth or tooth bounded spaces per quadrant	$305.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) — one to three contiguous teeth or tooth bounded spaces per quadrant	$155.00
D4263	Bone replacement graft — retained natural tooth — first site in quadrant	$225.00
D4264	Bone replacement graft — retained natural tooth — each additional site in quadrant	$175.00
D4266	Guided tissue regeneration— resorbable barrier, per site	$295.00
D4267	Guided tissue regeneration— non-resorbable barrier, per site (includes membrane removal)	$335.00
D4268	Surgical revision procedure, per tooth	Not Billable to Patient
D4270	Pedicle soft tissue graft procedure	$210.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$210.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$210.00
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	$105.00
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	$126.00
D4286	Removal Of Non-Resorbable Barrier	$45.00
D4341	Periodontal scaling and root planing — four or more teeth per quadrant — limited to 4 quadrants during any 12 consecutive months	$60.00
D4342	Periodontal scaling and root planing — one to three teeth per quadrant — limited to 4 quadrants during any 12 consecutive months	$30.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation — full mouth, after oral evaluation — 2 per 12 month period	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit — limited to 1 treatment in any 12 consecutive months	$45.00

DELTA DENTAL®

CODES		COPAYMENT
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$60.00
D4910	Periodontal maintenance — limited to 2 treatments each 12 month period	$35.00
D4921	Gingival irrigation with a medicinal agent — per quadrant	Not Billable to Patient
VI.	**PROSTHODONTICS, (removable)**	
D5110	Complete denture — maxillary	$485.00
D5120	Complete denture — mandibular	$485.00
D5130	Immediate denture — maxillary	$485.00
D5140	Immediate denture — mandibular	$485.00
D5211	Maxillary partial denture — resin base (including retentive/clasping materials, rests and teeth)	$430.00
D5212	Mandibular partial denture — resin base (including retentive/clasping materials, rests and teeth)	$430.00
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$560.00
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$560.00
D5221	Immediate maxillary partial denture — resin base (including retentive/clasping materials, rests and teeth)	$430.00
D5222	Immediate mandibular partial denture — resin base (including retentive/clasping materials, rests and teeth)	$430.00
D5223	Immediate maxillary partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$560.00
D5224	Immediate mandibular partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$560.00
D5227	Immediate maxillary partial denture — flexible base (including any clasps, rests and teeth	$430.00
D5228	Immediate mandibular partial denture — flexible base (including any clasps, rests and teeth)	$430.00
D5410	Adjust complete denture — maxillary	$30.00
D5411	Adjust complete denture — mandibular	$30.00
D5421	Adjust partial denture — maxillary	$30.00
D5422	Adjust partial denture — mandibular	$30.00
D5511	Repair complete denture base, mandibular	$65.00
D5512	Repair complete denture base, maxillary	$65.00
D5520	Replace missing or broken teeth – complete denture – per tooth	$57.00
D5521	Replace all teeth on complete denture – maxillary	$485.00

DELTA DENTAL®

CODES		COPAYMENT
D5522	Replace all teeth on complete denture – mandibular	$485.00
D5611	Repair resin denture base — mandibular	$65.00
D5612	Repair resin denture base — maxillary	$65.00
D5630	Repair or replace broken clasp — per tooth	$75.00
D5640	Replace missing or broken teeth – partial denture – per tooth	$63.00
D5650	Add tooth to existing partial denture – per tooth	$65.00
D5660	Add clasp to existing partial denture — per tooth	$75.00
D5710	Rebase complete maxillary denture	$175.00
D5711	Rebase complete mandibular denture	$175.00
D5720	Rebase maxillary partial denture	$175.00
D5721	Rebase mandibular partial denture	$175.00
D5725	Rebase hybrid prosthesis	$175.00
D5730	Reline complete maxillary denture — chairside	$100.00
D5731	Reline complete mandibular denture — chairside	$100.00
D5740	Reline maxillary partial denture — chairside	$100.00
D5741	Reline mandibular partial denture — chairside	$100.00
D5750	Reline complete maxillary denture — laboratory	$150.00
D5751	Reline complete mandibular denture — laboratory	$150.00
D5760	Reline maxillary partial denture — laboratory	$150.00
D5761	Reline mandibular partial denture — laboratory	$150.00
D5765	Soft liner for complete or partial removable denture — indirect	$150.00
D5810	Interim complete denture — maxillary	$229.00
D5811	Interim complete denture — mandibular	$229.00
D5820	Interim partial denture — including retentive/clasping materials, rests, and teeth — maxillary	$198.00
D5821	Interim partial denture — including retentive/clasping materials, rests, and teeth — mandibular	$198.00
VII.	MAXILLOFACIAL PROSTHETICS — NOT COVERED (D5900-D5999)	
VIII.	IMPLANT SERVICES — NOT COVERED (D6000—D6199)	
IX.	PROSTHODONTICS, fixed	
	(each retainer and each pontic constitutes a unit in fixed partial denture [bridge])	
D6210	Pontic — cast high noble metal	$405.00

DELTA DENTAL®

CODES		COPAYMENT
D6211	Pontic — cast predominantly base metal	$360.00
D6212	Pontic — cast noble metal	$385.00
D6240	Pontic — porcelain fused to high noble metal	$405.00
D6241	Pontic — porcelain fused to predominantly base metal	$360.00
D6242	Pontic — porcelain fused to noble metal	$385.00
D6245	Pontic — porcelain/ ceramic	$400.00
D6602	Retainer inlay — cast high noble metal, two surfaces	$405.00
D6603	Retainer inlay — cast high noble metal, three or more surfaces	$405.00
D6604	Retainer inlay — cast predominantly base metal, two surfaces	$360.00
D6605	Retainer inlay — cast predominantly base metal, three or more surfaces	$360.00
D6606	Retainer inlay — cast noble metal, two surfaces	$385.00
D6607	Retainer inlay — cast noble metal, three or more surfaces	$385.00
D6610	Retainer onlay — cast high noble metal, two surfaces	$405.00
D6611	Retainer onlay — cast high noble metal, three or more surfaces	$405.00
D6612	Retainer onlay — cast predominantly base metal, two surfaces	$360.00
D6613	Retainer onlay — cast predominantly base metal, three or more surfaces	$360.00
D6614	Retainer onlay — cast noble metal, two surfaces	$385.00
D6615	Retainer onlay — cast noble metal, three or more surfaces	$385.00
D6740	Retainer crown — porcelain / ceramic	$445.00
D6750	Retainer crown — porcelain fused to high noble metal	$405.00
D6751	Retainer crown — porcelain fused to predominantly base metal	$360.00
D6752	Retainer crown — porcelain fused to noble metal	$385.00
D6780	Retainer crown — ¾ cast high noble metal	$405.00
D6781	Retainer crown — ¾ cast predominantly base metal	$360.00
D6782	Retainer crown — ¾ cast noble metal	$385.00
D6790	Retainer crown — full cast high noble metal	$405.00
D6791	Retainer crown — full cast predominantly base metal	$360.00
D6792	Retainer crown — full cast noble metal	$385.00
D6930	Re-cement or re-bond fixed partial denture	$18.00

X.	ORAL AND MAXILLOFACIAL SURGERY	
	Includes preoperative and postoperative evaluations and treatment under a local anesthetic	
D7111	Extraction, coronal remnants — primary teeth	$5.00
D7140	Extraction, erupted tooth or exposed root — elevation and/or forceps removal	$5.00

DELTA DENTAL®

CODES		COPAYMENT
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$35.00
D7220	Removal of impacted tooth — soft tissue	$30.00
D7230	Removal of impacted tooth — partially bony	$65.00
D7240	Removal of impacted tooth — completely bony	$85.00
D7241	Removal of impacted tooth — completely bony, with unusual surgical complications	$85.00
D7250	Removal of residual tooth roots — cutting procedure	$35.00
D7260	Oroantral fistula closure	$85.00
D7261	Primary closure of a sinus perforation	$85.00
D7270	Tooth re-implantation and/or stabilization if accidentally evulsed or displaced tooth	No Cost
D7280	Exposure of an unerupted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands	Not Billable to Patient
D7285	Incisional biopsy of oral tissue — hard (bone, tooth)	$55.00
D7286	Incisional biopsy of oral tissue — soft	$45.00
D7310	Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	$40.00
D7320	Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	$55.00
D7450	Removal of benign odontogenic cyst or tumor— lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor— lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7485	Surgical reduction of osseous tuberosity	$55.00
D7510	Incision and drainage of abscess — intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Not Billable to Patient
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost

XI. ORTHODONTICS

Your Coinsurance is 50% of the Delta Dental PPO™ Dentist's Plan Allowance plus any amounts over the lifetime Benefit Maximum.

D0340	2-D Cephalometric radiographic image — acquisition, measurement and analysis	50%
D0350	2-D oral/facial photographic images obtained intraorally or extraorally	50%
D0470	Diagnostic casts	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%

DELTA DENTAL®

CODES		COPAYMENT
D8010	Limited orthodontic treatment of the primary dentition	50%
D8020	Limited orthodontic treatment of the transitional dentition	50%
D8030	Limited orthodontic treatment of the adolescent dentition	50%
D8040	Limited orthodontic treatment of the adult dentition	50%
D8070	Comprehensive orthodontic treatment of the transitional dentition	50%
D8080	Comprehensive orthodontic treatment of the adolescent dentition	50%
D8090	Comprehensive orthodontic treatment of the adult dentition	50%
D8091	Comprehensive orthodontic treatment with orthognathic surgery	50%
D8210	Adjunctive orthodontic therapy – removable appliance	50%
D8220	Adjunctive orthodontic therapy – fixed appliance	50%
D8660	Pre-orthodontic treatment examination to monitor growth and development	50%
D8670	Periodic orthodontic treatment visit	50%
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	50%
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	50%
D8689	Re-cement or re-bond orthodontic fixed appliance	50%
D8698	Re-cement or re-bond fixed retainer — maxillary	50%
D8699	Re-cement or re-bond fixed retainer — mandibular	50%
D8701	Repair of fixed retainer, includes reattachment — maxillary	Not Billable to Patient
D8702	Repair of fixed retainer, includes reattachment — mandibular	Not Billable to Patient

XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain — minor procedure	No Cost
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Not Billable to Patient
D9211	Regional block anesthesia	Not Billable to Patient
D9212	Trigeminal division block anesthesia	Not Billable to Patient
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not Billable to Patient
D9222	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	$87.00
D9223	Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	$58.00
D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	$87.00

DELTA DENTAL®

CODES		COPAYMENT
D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	$58.00
D9936	Cleaning and inspection of occlusal guard – per appliance	$37.00
D9239	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	$87.00
D9243	Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	$58.00
D9310	Consultation — diagnostic services provided by a dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	Not Billable to Patient
D9430	Office visit for observation (during regularly scheduled hours) — no other services performed	No Cost
D9440	Office visit — after regularly scheduled hours	$45.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	Not Billable to Patient
D9943	Occlusal guard adjustment	$30.00
D9944	Occlusal guard — hard appliance, full arch	$135.00
D9945	Occlusal guard — soft appliance, full arch	$135.00
D9946	Occlusal guard — hard appliance, partial arch	$135.00
D9951	Occlusal adjustment — limited	$25.00
D9952	Occlusal adjustment — complete	$140.00
D9990	Certified translation or sign-language services — per visit	Not Billable to Patient
D9991	Dental case management — addressing appointment compliance barriers	Not Billable to Patient
D9992	Dental case management — care coordination	Not Billable to Patient
D9995	Teledentistry — synchronous; real—tie encounter	Not Billable to Patient
D9996	Teledentistry — asynchronous; information stored and forwarded to dentist for subsequent review	Not Billable to Patient
D9997	Dental case management — patients with special health care needs	Not Billable to Patient

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Delta Dental High and Low Option plans

Limitations and Exclusions

LIMITATIONS

1. Oral exams are limited to twice in a Calendar Year.
2. Consultations and evaluations for deep sedation or general anesthesia are limited to twice in a Calendar Year. and are subject to the benefit limitation for regular exams.
3. Cleanings are limited to twice in a Calendar Year.
4. Periodontal cleanings are limited to twice in a Calendar Year.
5. Scaling in presence of generalized moderate or severe gingival inflammation is subject to the benefit limitation of a regular cleaning or periodontal maintenance.
6. Full mouth debridement is a Covered Benefit when an Enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
7. Full mouth debridement is limited to once in a lifetime.
8. Fluoride applications are limited to twice in a Calendar Year for Enrollees under the age of 19.
9. Bitewing X-rays are limited to twice in a Calendar Year; limited to a maximum of four bitewing films in one visit.
10. Full mouth/panelipse X-rays are limited to once in a five-year period.
11. Sealants and preventive resin restorations are limited to non-carious, non-restored first and second permanent molars for Enrollees under the age of 16, one application per tooth every three years.
12. Amalgam (silver) and composite (white) fillings are limited to once per tooth per surface in a 24-month period.
13. Space maintainers, not including distal shoe space maintainers, are limited to once per quadrant per arch per lifetime for Enrollees under the age of 14.
14. Distal shoe space maintainers are limited to once per quadrant per arch per lifetime for Enrollees under the age of nine.
15. Retreatment of root canal therapy is a Covered Benefit two years after initial root canal therapy and is limited to once in a lifetime.
16. Replacement of an existing crown not related to an implant is a Covered Benefit once every 60 months per tooth and when the existing crown is not serviceable.
17. Scaling and debridement of a single implant is limited to once per tooth in a 24-month period.
18. Recementation of existing crowns and inlays are limited to once in a 12 consecutive month period and only if performed more than six months after the placement of the initial crown or inlay.
19. Replacement of an existing prosthetic not related to an implant is a Covered Benefit once every 60 months and when the existing prosthesis is not serviceable.

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20. Denture adjustments are limited to twice in a 12 consecutive month period and only if performed more than six months after the placement of the initial denture.
21. Denture rebase and relines are limited to once in a 12 consecutive month period and only if performed more than six months after the placement of the initial denture.
22. Implants and implant supported prosthetics are limited to once in a life-time per site for Enrollees age 16 and older.
23. Implants are limited to two per quadrant and four per each arch with a maximum of eight for full mouth reconstruction.
24. Benefits for fillings, crowns and inlays are not allowed when performed on the same tooth within three months of an interim caries arresting medicament application. Interim caries arresting medicament applications are limited to two applications per tooth per calendar year.
25. A full mouth X-ray includes bitewing X-rays; panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
26. Prefabricated stainless steel crowns are limited to primary (baby) teeth for Enrollees under the age of 14.
27. Prefabricated stainless steel with resin window and prefabricated esthetic coated stainless steel crowns are limited to primary (baby) teeth for Enrollees age 19 and under.
28. Gingivectomy or gingivoplasty is limited to once per quadrant in a 36-month period.
29. Gingival flap procedures are limited to once per quadrant in a 36-month period.
30. Osseous surgery is limited to once per quadrant in a 36-month period.
31. Periodontal scaling and root planing is limited to once per quadrant in a 24-month period.
32. Autogenous and non-autogenous connective tissue graft procedures; distal or proximal wedge procedure; combined connective tissue and double pedicle graft procedures are limited to once per site in a 36-month period.
33. Fixed bridges or removable partials are limited to Enrollees age 16 and older.
34. Crowns are a Covered Benefit when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
35. Crowns are limited to Enrollees age 12 and older.
36. Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
37. Orthodontic services are limited to Enrollees age five and older.

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EXCLUSIONS

1. Services or supplies that are not related to a Dental Service or supply; also includes services or supplies not specifically listed as covered in the Schedule of Benefits.
2. Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist.
3. A dental service that Delta Dental, in its sole discretion after consultant review by a licensed Dentist, determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the dental services provided. In addition, each covered benefit must demonstrate dental necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry. All dental services are subject to established internal and external appeal processes available to you.
4. Dental services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
5. Dental services for the diagnosis or treatment for illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
6. Dental services started or rendered before the date enrolled under this dental plan. Also, except as otherwise provided for in the plan documents, benefits for a course of treatment that began before you are enrolled under this dental plan.
7. Dental services provided before the date you enrolled under this dental plan.
8. Except as otherwise provided in the plan documents, dental services provided after the date you are no longer enrolled or eligible for coverage under the plan document.
9. Except as otherwise provided for in plan documents, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
10. General anesthesia when less than three teeth will be routinely extracted during the same office visit.
11. Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
12. Charges for inpatient or outpatient hospital services; any additional fee that the dentist may charge for treating a patient in a hospital, nursing home or similar facility.
13. Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information.
14. Charges for failure to keep a scheduled appointment.
15. Charges for consultations in person, by phone or other electronic means.
16. Charges for X-ray interpretation.
17. Dental services to the extent that benefits are available or would have been available if you had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.

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18. Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under the plan or any similar coverage.
19. Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist's parent, spouse or child.
20. Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
21. Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
22. Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis.
23. Experimental or investigative dental procedures, services, or supplies, as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the enrollee's condition.
24. Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
25. Except as otherwise provided for in this EOC, Dental services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
26. Services billed under multiple procedure codes in which Delta Dental, in its sole discretion, determines that the service was either a component part of or inclusive of a more comprehensive or primary procedure code. This exclusion is subject to any and all internal and external appeals available to you. Delta Dental bases its payment on the plan allowance for the primary code, not on the plan allowance for the underlying component codes.
27. Services billed under a dental service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases its payment on its determination of the more accurate dental service code.
28. Amounts assessed on dental services and/or supplies by state or local regulation.
29. Amounts that exceed the plan allowance for covered benefits.

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Limitations and Exclusions

LIMITATIONS

Please refer to the Schedule of Benefits and Copayments/Coinsurance for a complete listing of Covered Benefits.

- Oral exams are limited to twice in a Calendar Year. Emergency exams are limited to once in a 12 consecutive month period.
- Consultations and evaluations for deep sedation or general anesthesia are limited to twice in a Calendar Year. and are subject to the benefit limitation for regular exams.
- Cleanings are limited to twice in a 12 consecutive month period.
- Periodontal cleanings are limited to twice in a 12 consecutive month period.
- Scaling in presence of generalized moderate or severe gingival inflammation is subject to the benefit limitation of a regular cleaning or periodontal maintenance.
- Full mouth debridement is a Covered Benefit when an Enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
- Full mouth debridement is limited to once in a 12 consecutive month period.
- Fluoride applications are limited to twice in a Calendar Year for Enrollees under the age of 19.
- Bitewing X-rays are limited to twice in a Calendar Year; limited to a maximum of four bitewing films in one visit or a set of (seven to eight) vertical bitewing films.
- Full mouth/panelipse X-rays are limited to once in a 24-month period.
- Sealants and preventive resin restorations are limited to non-carious, non-restored first and second permanent molars for Enrollees under the age of 16, one application per tooth.
- Amalgam (silver) and composite (white) fillings are limited to once per tooth per surface in a 24-month period.
- Space maintainers, not including distal shoe space maintainers, are limited to once per quadrant per arch per lifetime for Enrollees under the age of 14.
- Distal shoe space maintainers are limited to once per quadrant per arch per lifetime for Enrollees under the age of nine.
- Retreatment of root canal therapy is a Covered Benefit two years after initial root canal therapy and is limited to once in a lifetime.
- Replacement of an existing crown not related to an implant is a Covered Benefit once every five years per tooth and when the existing crown is not serviceable.
- Recementation of existing crowns and inlays are limited to once in a 12 consecutive month period.

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- Replacement of an existing prosthetic not related to an implant is a Covered Benefit once every five years and when the existing prosthesis is not serviceable.
- Denture adjustments are limited to twice in a 12 consecutive month period and only if performed more than six months after the placement of the initial denture.
- Denture rebase and relines are limited to twice in a 12 consecutive month period and only if performed more than six months after the placement of the initial denture.
- Benefits for fillings, crowns and inlays are not allowed when performed on the same tooth within three months of an interim caries arresting medicament application. Interim caries arresting medicament applications are limited to two applications per tooth per calendar year.
- A full mouth X-ray includes bitewing X-rays; panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
- Prefabricated stainless steel crowns are limited to primary (baby) teeth for Enrollees under the age of 14.
- Prefabricated stainless steel with resin window and prefabricated esthetic coated stainless steel crowns are limited to primary (baby) teeth for Enrollees age 19 and under.
- Gingivectomy or gingivoplasty is limited to once per quadrant in a 36-month period.
- Gingival flap procedures are limited to once per quadrant in a 36-month period.
- Osseous surgery is limited to once per quadrant in a 36-month period.
- Periodontal scaling and root planing is limited to once per quadrant in 12 consecutive months.
- Autogenous and non-autogenous connective tissue graft procedures; distal or proximal wedge procedure; combined connective tissue and double pedicle graft procedures are limited to once per site in a 36-month period.
- Fixed bridges or removable partials are limited to Enrollees age 16 and older.
- Crowns are a Covered Benefit when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
- Crowns are limited to Enrollees age 12 and older.
- Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
- Orthodontic services are limited to Enrollees age five and older.

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EXCLUSIONS

The following are not Covered Benefits unless specifically identified as a Covered Benefit in the Schedule of Benefits and Copayment/Coinsurance:

- Services or supplies that are not related to a Dental Service or supply; also includes services or supplies not specifically listed as covered in the Schedule of Benefits and Copayment/Coinsurance.
- Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist.
- A Dental Service that Delta Dental, in its sole discretion after consultant review by a licensed Dentis, determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Dental Necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry. All Dental services are subject to established internal and external appeal processes available to you.
- Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental Services for the diagnosis or treatment of illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
- Dental Services started or rendered before the date enrolled under this EOC. Also, except as otherwise provided in this EOC, benefits for a course of treatment that began before you were enrolled under this EOC.
- Dental services provided before the date you enrolled under this EOC.
- Except as otherwise provided for in this EOC, Dental Services provided after the date you are no longer enrolled or eligible for coverage under this EOC.
- Except as otherwise provided for in this EOC, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit.
- Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information.
- Charges for failure to keep a scheduled appointment.
- Charges for consultations in person, by phone or by other electronic means.
- Charges for X-ray interpretation.

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- Dental Services to the extent that benefits are available or would have been available if you had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or Dental Services for which you would not be obligated to pay in the absence of the coverage under this EOC or any similar coverage.
- Services or treatment provided to an immediate family member by the treating Dentist. This would include a Dentist's parent, spouse or child.
- Dental Services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
- Dental Services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee's condition.
- Dental Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
- Except as otherwise provided for in this EOC, Dental Services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
- Services billed under multiple procedure codes in which Delta Dental, in its sole discretion, determines that the service was either a component part of or inclusive of a more comprehensive or primary procedure code. This exclusion is subject to any and all internal and external appeals available to you. Delta Dental bases its payment on the Plan Allowance for the primary code, not on the Plan Allowance for the underlying component codes.
- Services billed under a Dental Service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the Dental Service. Delta Dental bases its payment on its determination of the more accurate Dental Service code.
- Amounts assessed on dental services and/or supplies by state or local regulation.
- Amounts that exceed the Plan Allowance for Covered Benefits.

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Enrollment instructions

(for paper enrollment)

1. Review the benefits summary to determine the plan best suited for your individual or family needs.
2. Complete the following information on the enrollment form. **PLEASE PRINT**
   - Social security number
   - Name
   - Address
   - Date of birth
   - Date of hire
   - Marital status
   - Type of plan
   - Type of coverage
   - Dependent information, if applicable

   a) If you have chosen the Delta Dental High or Low Option plan:
      - Mark the “Delta Dental High Option plan” or “Delta Dental Low Option plan” box under “Product”.

   b) If you have chosen the Delta Dental EPO™:
      - Mark the “Delta Dental EPO™” box under “Product”.
3. Sign and date the enrollment form and return to the Schools Benefits Office or the General Government’s Department of Human Resources.
4. If you have any questions, please call the Schools Benefits Office at 804.652.3624 or the General Government’s Department of Human Resources at 804.501.7371.



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