DELTA DENTAL OF NEW JERSEY, INC.

Delta Dental PPO - FIXED COPAY PROGRAM

Dental Benefits

Member Booklet

Delta Dental PPO Network

MOUNT LAUREL TOWNSHIP BOARD OF EDUCATION

Group # 07654

Topics Covered in This Booklet

Please note: The definitions for the words that appear in bold in the following pages can be found in the Glossary.

Section 1 - About This Booklet

This **Booklet** contains a description of this **Delta Dental PPO – Fixed Copay Program** for your dental benefits. The dental benefits are selected by the plan sponsor and underwritten by Delta Dental of New Jersey, Inc. This **Booklet** is not a Summary Plan Description designed to meet the requirements of ERISA.

Section 2 - About Delta Dental

Delta Dental of New Jersey, Inc. (**Delta Dental**) covers more than one million people in commercial, school board, and government programs. It is our mission to promote oral health to the greatest number of people by providing accessible dental benefit programs of the highest quality, service, and value.

Since 1969, **Delta Dental**, not-for-profit New Jersey dental service corporation, has led the industry in offering innovative programs designed to control costs while ensuring quality of benefits.

Delta Dental is a member of the Delta Dental Plans Association, a national system of not-for-profit dental service corporations covering 89 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country.

In New Jersey, Delta Dental of New Jersey, Inc. writes dental coverage on an insured basis. It also administers self-funded dental benefit programs in New Jersey and Connecticut.

Section 3 - Eligibility Requirements

Your employer has determined who eligible for dental benefits, including whether your plan provides dental benefits for eligible **Dependents**. You and your eligible spouse, civil union spouse, domestic partner and children to age 23 are eligible for Benefits under this **Delta Dental PPO – Fixed Copay Program**. Your employer may ask you to fill out an enrollment form. If you have questions regarding eligibility, please check with your employer.

When does coverage terminate?

- Your dental benefits or those of your eligible **Dependents** shall cease on the last day of the month that your coverage, as the **Subscriber,** terminates. Coverage terminates upon the earliest of:
  - Termination of the **Subscriber's** or **Dependent's** eligibility as determined by the employer.
  - Termination of your employment.
  - Termination of the Master Group Contract between **Delta Dental** and the employer or termination or expiration of the contract term.

Your employer will provide you with notice of termination of dental benefits.

Upon termination of your dental benefits, your employer will provide you with notice of your rights to continuation of coverage under federal COBRA law or state continuation of benefits law.

Section 4 - Product Description and Network

This is a **Delta Dental PPO – Fixed Copay Program** that has a **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits attached. **Delta Dental** will pay for **Benefits** only for **Procedures** listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits, subject to all limits and exclusions listed in this **Booklet.** You are responsible for paying the corresponding co-payment listed in the schedule. If a **Procedure** is not listed or if it has no corresponding co-payment, the service is not a **Covered Service** and not eligible to receive a **Benefit** under this **Delta Dental PPO – Fixed Copay Program.** **Benefits** are available only for **Covered Services** you receive from a **Delta Dental PPO Dentist**. If you receive services from a **Delta Dental Premier Dentist** or from a **Non-Participating Dentist,** you shall receive no **Benefit,** except in the case of an emergency service that is limited to an emergency exam and palliative treatment with a maximum annual **Benefit** payment of $300. Please note that your benefits do not include coverage of the pediatric dental services that meet the requirements of the federal Patient Protection Affordable Care Act.

Delta Dental PPO Network

Under this plan, you can only receive **Dental Services** from **Dentists** that participate in the **Delta Dental PPO Network**. **Dentists** that participate in the **Delta Dental PPO Network** include **General Dentists** and specialists.

Dentists that are in the **Delta Dental Premier** network and **Non-Participating Dentists** that are not part of the **Delta Dental** network are considered "out-of-network," and you will receive no **Benefit** when you received services from them, unless in the case of emergency that is limited to an emergency exam and palliative treatment with a maximum annual **Benefit** payment of $300.

When you receive **Covered Services** from a **Delta Dental PPO Dentist**, the **Dentist** has agreed to accept the **Delta Dental's** payment and your fixed co-payment amount listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits as payment in full.

Section 5 - How to Use Your Dental Benefits

Before visiting the **Dentist**, make sure your **Dentist** is a **Delta Dental PPO Dentist**.

At the time of your first appointment, tell your **Delta Dental PPO Dentist** that you are covered under this **Delta Dental PPO – Fixed Copay Program.** Give him or her the name of the group through which you have coverage, the group number, as well as your Member ID number. If your **Dependents** are covered, they must also provide your information.

After your **Delta Dental PPO Dentist** performs an examination, although your financial responsibility should be listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits, he or she may still submit a **Pre-Treatment Estimate** of benefits to **Delta Dental** to make sure that the service is covered and determine how much of the charge for any future work will be your responsibility.

Before treatment is started, be sure you discuss with your **Dentist** the total amount of his or her fee. Although **Pre-Treatment Estimates** are not required, **Delta Dental** strongly recommends you ask your **Dentist** to submit a **Pre-Treatment Estimate** for treatment costing $300 or more. The **Pre-Treatment Estimate** lets you know in advance how much of the costs are your responsibility. Please keep in mind that a **Pre-Treatment Estimate** is only an estimate and not a guarantee of benefits or payment.

Remember that you will not receive any **Benefit** for services you receive from a **Delta Dental Premier Dentist** or a **Non-Participating Dentist.**

Section 6 - Locating a Delta Dental PPO Dentist

Delta Dental offers two easy ways to locate a **Delta Dental PPO Dentist.**

- Call 1-800-452-9310 during normal business hours or
- On-line at www.deltadentalnj.com

By calling the toll-free number, you can obtain a customized list of **Delta Dental PPO Dentists** within the geographic area of your request. **Delta Dental** mails the list to your home.

By searching our website's Find A Dentist tool, you can obtain a list of **Delta Dental PPO Dentists** in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

You can specify listings of general **PPO Dentists** or **PPO Dentists** that are specialists. You can get search to find **Delta Dental PPO Dentists** nationwide.

Section 7 – Useful Information Regarding Delta Dental PPO Dentists

All **Delta Dental PPO Dentists** have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- **Delta Dental PPO Dentists** have agreed to accept the least of their actual charge, their prefiled fee, or the fee listed in **Delta Dental's** PPO fee schedule as payment in full and to not charge **Covered Persons** more than the "patient payment" portion of the **Explanation of Benefits,**

which amount shall equal the co-payment in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits.

- **Delta Dental PPO Dentists** will usually maintain a supply of **Claim Forms** (also referred to as Attending **Dentist**'s Statements) in their office. You may be asked to complete a portion of the form when you visit.

- **Delta Dental PPO Dentists** will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a **Pre-Treatment Estimate**, and require that you sign the **Claim Form** in the appropriate place. If your **Dentist** submits **Claims** electronically to **Delta Dental**, you will need to authorize your **Dentist** to maintain your signature on file.

- **Delta Dental PPO Dentists** will mail, fax, or electronically submit the **Claim Form,** together with the appropriate diagnostic materials, directly to our offices for processing.

- **Delta Dental Dentists** agree to abide by **Delta Dental** processing policies. For example, **Delta Dental PPO Dentists** agree not to bill separate charges for infection control measures.

- **Delta Dental PPO Dentists** will, in the case of **Dental Services** which have been completed, receive payment directly from **Delta Dental** for that portion of the **Treatment Plan** which is covered by this **Delta Dental PPO – Fixed Copay Program.** You will receive an **Explanation of Benefits** with a detailed description of covered benefits and the amount of your payment obligation that should also be listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits.

Remember that you will receive no **Benefit** if you receive services from a **Delta Dental Premier Dentist** or a **Non-Participating Dentist**, since they are considered "out-of-network" for this **Delta Dental PPO – Fixed Copay Program** and you will be responsible for the full amount of their charges.

Check with your **Dentist** to confirm whether he or she participates in the **Delta Dental** PPO **Network**. While a **Dentist** may say he or she accepts **Delta Dental** or participate with **Delta Dental**, he or she may not participate in the **Delta Dental PPO Network**, which is the only network eligible to receive **Benefits** under this **Delta Dental PPO – Fixed Copay Program**.

Section 8 – DELTA DENTAL PPO – FIXED COPAY PROGRAM COVERAGE TERMS AND SCHEDULE OF BENEFITS

The following sections outline the Benefits and Coverage Terms that apply to this **Delta Dental PPO – Fixed Copay Program**. **It is important for you to know that not all Dental Services you may need are Covered Services under this Delta Dental PPO – Fixed Copay Program. Only those Procedures and Procedure codes listed in the Delta Dental PPO – Fixed Copay Program Schedule of Benefits are Covered Services.** And, only those services you receive from a **Delta Dental PPO Dentist are Covered Services, unless the service is an emergency** that is limited to an emergency exam and palliative treatment with a maximum annual benefit payment of $300**. Services listed on the Delta Dental PPO – Fixed Copay Program** Schedule of Benefits **are also subject to the Limitations and Exclusions listed in this Booklet.**

(a) **Payment for Orthodontic Services:** Orthodontic Services are covered for all persons. Subject to all other conditions set forth in this Section, **Delta Dental** will, following payment by the **Covered Person** of the applicable fixed co-payment amount set forth in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits, pay the remainder of the **Allowed Amount** for the orthodontic **Treatment Plan** started while the **Covered Person** was enrolled in this **Delta Dental PPO – Fixed Copay Program** in monthly installments. For orthodontic treatment started before the **Covered Person** became enrolled in this **Delta Dental PPO – Fixed Copay Program, Delta Dental** will, following payment by the **Covered Person** of the applicable fixed co-payment amount set forth in the **Fixed Co-Payment** Schedule of Benefits**,** pay the remainder of the **Allowed Amount** applicable to the **Delta Dental PPO Dentist** in monthly installments for the remainder of the approved orthodontic **Treatment Plan. Delta Dental's monthly installment payments shall be based on** its payment share of the **Allowed Amount** divided by the total number of months in the entire period of the approved orthodontic treatment. To be eligible for a **Benefit,** the **Covered Person** must still be in active treatment and maintain current eligibility and enrollment in this **Fixed Copay PPO Plan.**

(b) **Fixed Co-Payment:** The **Covered Person's** payment obligation for each **Covered Service** is listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits. If the **Procedure** is not listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits, it is not a **Covered Service** and the **Covered Person** shall be responsible for the full amount of the **Dentist's** billed charge. If a **Covered Service** is not provided by a **Delta Dental PPO Dentist**, this **Delta Dental PPO – Fixed Copay Program** will provide no **Benefit.** This **Delta Dental PPO – Fixed Copay Program** provides no **Benefit** for services obtained from a **Delta Dental Premier Dentist** or from a **Non-Participating Dentist.** Both **Delta Dental Premier Dentists** and **Non-Participating Dentists** that are not part of the **Delta Dental** network are considered "out-of-network" and no **Benefit** is available under this **Delta Dental PPO – Fixed Copay Program** for services they provide except in the case of

emergency that is limited to an emergency exam and palliative treatment with a maximum annual benefit payment of $300. **Delta Dental's** payment obligation for **Covered Services** that are listed on the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits are subject to all other provisions in this **Booklet** including frequency limitations, age limitations on certain **Procedures** , and other limitations and **Exclusions**. **Delta Dental's Benefit** shall be based on the difference between the applicable **Approved Amount** in the **Delta Dental PPO Dentist** schedule and the **Covered Person's** fixed co-payment responsibility listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits**.**

(c) **Benefit Limitations and Exclusions:** This **Delta Dental PPO – Fixed Copay Program** does not cover every aspect of dental care or every **Dental Service** recommended or performed by a **Dentist**. Only the **Procedures** listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits are **Covered Services** and those services and **Procedures** are also subject to **Benefit Limitations** and **Exclusions**. If a service is not eligible for a **Benefit**, the **Covered Person** is obligated to pay the **Dentist** the full **Approved Amount** for that **Dental Service**.

SCHEDULE OF DENTAL BENEFITS AND CO-PAYMENTS

Subject to the limitations, **Exclusions** and **Covered Persons** co-payments set forth herein, the following services shall be performed as needed and deemed necessary by the **PPO Dentist**:

1. **ATTACHED AS APPENDIX A**
2. **ATTACHED AS APPENDIX B**

Orthodontic Payment Schedule

Payment for **Comprehensive** orthodontics will be processed in equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered).

When the appliances are inserted by a **Delta Dental PPO Dentist** prior to the effective date of eligibility, orthodontic benefits will be **Pro-rated.**

Section 9 - Description of Eligible Dental Services Subject to the Procedure Listing in the Delta Dental PPO – Fixed Copay Program Schedule of Benefits

(a) Diagnostic and Preventive

(i) ***Covered Services***

Diagnostic:

Provides the necessary **Procedures** to assist the **Dentist** in evaluating the existing conditions to determine the required dental treatment. These services include: oral examination and diagnostic services (including necessary dental x-rays).

Preventive:

Oral **Prophylaxis**. Topical application of fluoride. Space maintainers, except when used as an activating device, once per space for missing posterior teeth for children under age 14.

(ii) ***Limitations***

Diagnostic:

Examinations are limited to two (2) per **Calendar Year**, Panorex or complete mouth radiograph series will be provided only once in a five (5)-year period, unless special need is shown. After such complete mouth radiograph, at least 6 months must elapse before a supplementary **Bitewing** radiograph will be benefitted. Supplementary **Bitewing** radiographs will be provided at most twice per **Calendar Year** for **Covered Persons** prior to attaining 19 years of age and at most once per **Calendar Year** for **Covered Persons** age 19 or more, unless special need is shown.

Preventive:

(A) **Prophylaxis** is limited to two (2) per **Calendar Year**.

(B) Topical application of fluoride will only be provided to **Covered Persons** prior to attaining 19 years of age, and only twice per **Calendar Year**.

(C) Application of **Sealants** (i.e., topically applied resin material used to seal development grooves and pits in teeth for the purpose of preventing decay) is a **Covered Service** only for **Dependents** under 16 years of age; includes the application of **Sealants** only to occlusal surfaces of permanent molar teeth (not including third molars) with the occlusal surfaces intact, no

occlusal caries (decay), and with no occlusal restorations; and does not include any repair or replacement of a **Sealant** on any tooth. (Such repair or replacement is considered to be included in the fee for the initial placement of the **Sealant**). The application of a **Sealant** is a **Covered Service** only once in a lifetime per tooth.

Emergency Care:

Necessary palliative treatment or other emergency care relating to any eligible **Dental Services** under this plan.

Note that Emergency Care received from a **Dentist** that is not a **Delta Dental PPO Dentist** is limited to an emergency exam and palliative treatment with a maximum annual benefit payment of $300.

(iii) ***Specific Exclusions***

(A) **Procedures** primarily for the purpose of plaque control (except **Prophylaxis**), oral hygiene, dietary instructions or other diagnostic tests not specifically mentioned, including but not limited to, laboratory tests, susceptibility tests and periodontal susceptibility tests.

(B) Periodontal scaling is not an eligible service when provided **In Conjunction With Prophylaxis**.

(b) Basic

(i) ***Covered Services***

Diagnostic:

Cone beam CT capture and interpretation for field of view of: less than one whole jaw; one full dental arch – mandible; one full dental arch - maxilla with or without cranium; or full view of both jaws with or without cranium subject to limitations and **Exclusions**. Cone beam CT capture and interpretation for TMJ series including two or more exposures.

Restorative:

Restorations consisting of silver **Amalgam**, acrylic, plastic or silicate cement (or other material approved by **Delta Dental** at its sole discretion)

(ii) ***Limitations***

(A) Tooth preparation, acid etching, temporary restorations, bases, pulp caps, impressions, local anesthesia and other services which are part of a complete dental **Procedure** are considered components of that complete dental **Procedure** and are included in the fee for that complete dental **Procedure**.

(B) Cone beam CT capture and interpretation is limited to one (1) per **Calendar Year**. Cone beam CT capture and interpretation for TMJ is limited to once in a lifetime.

(iii) ***Specific Exclusions***

(A) Surgical **Procedures** to correct congenital malformations or development malformations, and **Procedures** , appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMD or occlusal equilibration.

(B) Allowance is made for only one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed and replacement is limited to once in a twelve (12)-month period.

(C) Any endodontic, periodontal, oral surgical and restorative **Procedures** related to overdentures.

(c) Crowns/Inlays/Onlays

(i) ***Covered Services***

Crowns, inlays and onlays when teeth cannot be restored with silver **Amalgam** or **Composite** resins (or other material approved by **Delta Dental** at its sole discretion). **Benefits** will be limited to teeth that cannot be restored by any other means, including severe loss of tooth structure resulting from caries and/or fracture.

(ii) ***Limitations***

Replacement of crowns, inlays, onlays, post and cores and core buildups will be made only after five (5) years have elapsed from the date of the prior major restorative (i.e., crown, inlay, onlay, pontic) services, even if not covered by **Delta Dental** at the time of the prior service.

(iii) ***Specific Exclusions***

Periodontal splinting and/or crown and bridgework used **In Conjunction With** periodontal splinting.

(d) Endodontics

(i) ***Covered Services***

Necessary **Procedures** for pulpal therapy and root canal therapy.

(ii) ***Limitations***

Root Canal Therapy is limited to permanent teeth, unless no permanent successor is present, and is limited to once per tooth in a lifetime.

(iii) ***Specific Exclusions***

(A) Any endodontic, periodontal, oral surgical and restorative **Procedures** related to overdentures.

(B) Synthetic graft materials.

(C) Extraoral grafts.

(e) Periodontics

(i) ***Covered Services***

Necessary procedures for treatment of the tissues supporting the teeth.

(ii) ***Limitations***

(A) Periodontal surgery is an eligible service only once in a three (3)-year period including any surgical re-entry and is limited to treatment of periodontal disease only and not for pre-restorative (crown lengthening purposes).

(B) Periodontal scaling and root planing in the same quadrant are limited to once every two (2) years.

(iii) ***Specific Exclusions***

(A) Any endodontic, periodontal, oral surgical and restorative **Procedures** related to overdentures.

(B) Curettage is not an eligible service **In Conjunction With** periodontal surgery.

(C) Periodontal splinting and/or crown and bridgework used **In Conjunction With** periodontal splinting.

(D) Periodontal scaling is not an eligible service when provided **In Conjunction With Prophylaxis**.

(E) Periodontal **Prophylaxis** will only be an eligible service after active Periodontal Therapy has been performed.

(F) Synthetic graft materials.

(f) Prosthodontics

(i) ***Covered Services***

Dental Prosthesis is to be provided where masticatory function is impaired and/or teeth are missing. Full or partial dentures should be constructed when deemed necessary to replace missing teeth (not including third molars). The adjustment or repair of existing prosthetic appliances is included. Fixed bridgework will only be a **Covered Service** when the use of a removable prosthetic device is inadequate.

(ii) ***Limitations***

(A) Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances satisfactory will be provided in accordance with this **Delta Dental PPO – Fixed Copay Program.** Prosthodontics appliances including abutment crowns will be replaced only after five (5) years have elapsed from the date of prior service. For purpose of replacement, a single crown is equivalent to an abutment crown, pontic or an onlay.

(B) If, in the provision of prosthodontics services, the **Covered Person** and the **Dentist** decide on personalized restorations or employ specialized techniques as opposed to standard **Procedures** , **Delta Dental** will allow the appropriate amount for the standard denture toward such treatment and the **Covered Person** is responsible for the difference in cost.

(C) A fixed bridge is not an eligible service **In Conjunction With** an allowance for a partial denture in the same arch.

(D) **Benefits** for fixed bridges and removable cast partial dentures are not provided for patients under sixteen (16) of age.

(E) Relines, adjustments, repairs and rebases are not payable within six (6) months of insertion of the prosthesis.

(iii) ***Specific Exclusions***

(A) Personalization, characterization and precision attachments.

(B) Any endodontic, periodontal, oral surgical and restorative **Procedures** related to overdentures.

(g) Oral Surgery

(i) ***Covered Services***

Extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures, and surgical and adjunctive treatment for minor pathological conditions. General anesthesia when administered in a dental office by a **Dentist** licensed to perform this service.

(ii) ***Specific Exclusions***

(A) Surgical **Procedures** to correct congenital malformations or development malformations, and **Procedures** , appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMD or occlusal equilibration

(B) Any endodontic, periodontal, oral surgical and restorative **Procedures** related to overdentures.

(C) Synthetic graft materials.

(D) Extraoral grafts**.**

(E) Hospital charges for room and board, and hospital charges for outpatient surgery.

(h) Orthodontics

(i) *Covered Services*

Comprehensive Orthodontic Services for a correctable major malocclusion that significantly interfere with proper form and function of the dentition, if prescribed in a **Treatment Plan** (Attending **Dentist's** Statement), and consisting of the initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of existing malocclusion and its attendant sequelae through the correction of malposed teeth.

(ii) *Limitations*

(A) All **Covered Person**s are eligible to receive orthodontic services.

(B) For the purpose of determining **Benefit** payments available for treatment in progress at the commencement or termination of a **Covered Person's** coverage hereunder, all orthodontic services shall be deemed to have been rendered on the date such services were performed.

(C) **Delta Dental's** obligation to make monthly payments for orthodontic services set forth in an approved **Treatment Plan** shall cease upon termination of orthodontic treatment for any reason prior to the completion of the services set forth in the **Treatment Plan**.

(D) If a **Covered Person** is receiving orthodontic services when his coverage under this **Contract** begins, **Delta Dental** shall only be responsible to make payment for the cost of that portion of the **Covered Person's** orthodontic services which corresponds to the time period during which the **Covered Person** is actually covered by this **Contract**.

(iii) *Specific Exclusions*

(A) The replacement and/or repair of any appliance furnished under a **Treatment Plan** shall not be a **Covered Service** under this **Contract**.

(B) After the completion of orthodontic services as set forth in a **Treatment Plan**, any further orthodontic services rendered to the same **Covered Person** shall not be a **Covered Service** under this **Contract**.

(C) Orthodontic surgery (orthognathic surgery).

(D) Tooth guidance appliance, minor tooth movement and pre-prosthetic orthodontics, such as molar uprighting.

(E) Myofunctional Therapy.

Section 10 - Basis and Extent of Delta Dental Payment

(a) Services by Delta Dental PPO Dentists

Payment for **Covered Services** rendered to **Covered Persons** by **Delta Dental PPO Dentists** shall be as follows:

Delta Dental shall pay or otherwise discharge for each **Covered Person** who receives eligible **Dental Services** completed by a **Delta Dental PPO Dentist**, the **Allowed Amount based on the** lower of the **Dentist's** charge or the amount set forth in the applicable PPO fee schedule after deducting the **Covered Person's** payment obligation (fixed co-payment) in the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits.**

Benefits are subject to application of **Benefit Limitations** and **Exclusions**.

The **Covered Person's** shall be responsible for the difference between **Delta Dental's Benefit Amount** and the co-payment listed in the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits** for the corresponding **Procedure**.

Delta Dental shall pay no **Benefit** to a **Covered Person** for a **Procedure** not listed in the **Delta Dental PPO – Fixed Copay Program** Schedule of Benefits**. Delta Dental** shall pay no **Benefit** for services received by a **Covered Person** from a **Delta Dental Premier Dentist** or **Non-Participating Dentist.**

Section 11- Exclusions and Limitations: Services Not Covered by This Dental Plan

To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a **Procedure** is prescribed by your **Dentist** does not make it dentally necessary or eligible for **Benefits** under this **Delta Dental PPO – Fixed Copay Program** . We can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of a **Benefit** or payment for a service.

No **Benefit** payment shall be provided for:

(i) Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; services which are provided by any Federal or State or Provincial government agency or are provided without cost to the **Covered Person** by any person, municipality, county or political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable eligible dental benefits contained under the **Delta Dental PPO – Fixed Copay Program**.

(ii) Services performed or items furnished for any conditions, disease, ailment or injury occurring while the **Covered Person** is on active duty during military service, or for services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.

(iii) **Dental Services** performed prior to the date the **Covered Person** became eligible for **Benefits** under the dental benefit plan unless the treatment was a year in duration and was completed after the **Covered Person** became eligible for and enrolled in this **Delta Dental PPO – Fixed Copay Program**.

(iv) Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.

(v) Treatments, services, diagnostic tests, or **Procedures** of an experimental nature,

(vi) Charges for hospitalization, including hospital visits.

(vii) Laboratory tests and/or laboratory examinations.

(viii) Services to correct minor tooth movement.

(ix) Any service or item which is determined by **Delta Dental's** Dental Director not to be a necessary service or item for the treatment of the **Covered Person's** condition, disease or injury. **Delta Dental** reserves the right to review the **Covered Person's** dental records, including necessary radiographs, photographs, and models to recommend whether a service or item is necessary. Such determination is subject to appeal.

(x) Broken appointments.

(xi) Completion of **Claim** forms and **Pre-Treatment Estimates**; copying or providing documents or radiographs.

(xii) Periodontal charting is considered a component of the diagnosis and treatment of periodontal disease and is not a chargeable **Procedure**.

(xiii) Infection control and OSHA **Procedures** are not chargeable to a **Covered Person**.

(xiv) Any service that has not been performed by a person duly licensed as an oral surgeon or as a **Dentist** in the state in which the treatment was rendered or by their auxiliary personnel in accordance with applicable law.

(xv) Expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

(xvi) Expenses for replacement of a lost, missing or stolen prosthetic device or other duplicate appliance.

(xvii) Expenses for services or supplies for which no charge is made that the **Covered Person** is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.

(xviii) Expenses for myofunctional therapy.

(xix) Expenses for appliances or restorations necessary to alter vertical dimension or to restore occlusion.

(xx) Expenses for services or supplies for accidental injury.

(xxi) Expenses which are incurred in connection with any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except as required by N.J.A.C. 11:3-27.3. For expenses incurred in connection with any injury or disease arising out of the ownership, maintenance, or use of a motor vehicle, this Contract shall be secondary.

(xxii) Duplicative **Dental Services** performed on the same day.

(xxiii) **Delta Dental** will not coordinate benefits unless the other plan provides benefits for **Dental Services** pursuant to the Section heading – If You Have Coverage Through Another Plan-Coordination of Benefits.

(xxiv) A subset of a more **Comprehensive Service** (or a lesser **Dental Service** considered included in the **Comprehensive Service**).

(xxv) Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases.

(xxvi) **Dental Services** submitted for payment as part of a **Claim** which has knowingly inaccurate information pertinent to the **Claim** (such as the **Dental Service** actually rendered, the date of service, the existence of other coverage, or the fee for the **Dental Service**).

(xxvii) Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; post removal; gingivectomy **In Conjunction With** restorations; impressions; lab fees and material; local anesthesia services **In**

Conjunction With operative or surgical **Procedures** , and other **Dental Services** which **Delta Dental** considers to be part of a more **Comprehensive Dental Service**.

(xxviii) Home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use.

(xxix) **Dental Services** for which the **Dentist** does not normally charge.

(xxx) **Dental Services** to diagnose or treat jaw joint disorders, such as, but not limited to, myofascial pain syndrome

(xxxi) **Dental Services** which have not been completed during the **Coverage Period**.

(xxxii) Sales taxes on **Dental Services**.

(xxxiii) Surgical **Procedures** to correct congenital malformations or development malformations, and **Procedures** , appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMD or occlusal equilibration.

(xxxiv) Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional **Procedure** (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)

(xxxv) Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.

(xxxvi) Temporary **Procedures** and appliances, pulp caps, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.

(xxxvii) Post removal (not **In Conjunction With** root canal therapy).

(xxxviii) Maxillofacial surgery and prosthetic appliances.

(xxxix) Chemical irrigation and guided tissue regeneration.

(xl) Charges for house calls.

(xli) Fluoride gel rinses and preparations for home use.

(xlii) Transplants

(xliii) All other services not specifically included in this **Delta Dental PPO – Fixed Copay Program** that are not listed as a **Covered Service** in the **Delta Dental PPO – Fixed**

Copay Program Schedule of Benefits.

Section 12- Other Payment Rules that Affect the Coverage

(a) **Dental Services Requiring Multiple Visits:** Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, orthodontia, and endodontic **Procedures**. **Delta Dental** will pay for **Covered Services** that need multiple visits only upon completion of the **Dental Services**. The **Completion Date** is deemed to be the date of service for these **Dental Services**.

(b) **In-Process Treatment: Dental Services** started before the person is a **Covered Person** are not entitled to any **Benefit**. Examples of the **Dental Services** which may be performed over more than one visit include, but are not limited to, fixed bridgework, full or partial dentures, crowns, and root canal therapy. The **Completion Date** of these **Dental Services** must occur before the **Coverage Expiration Date** in order for them to be due any **Benefit**. The **Completion Date** is the date of insertion for removable prosthetic appliances; the insertion date for fixed partial dentures and for crowns, and onlays, and inlays is the cementation date, no matter what the type of cement is used. The **Completion Date** for root canal therapy is the date the canals are permanently filled.

(c) If the dental benefit plan provides coverage for orthodontic services, **Benefits** for in process orthodontic services will be prorated so that **Delta Dental** pays a **Benefit** based on the length of time the **Covered Person** is covered under the dental benefit plan**t** as compared to the total amount of time for which the **Covered Person** will have received those **Dental Services**. For example, if the **Dental Services** plan is for twenty-four (24) months and (10) months of treatment have already been performed prior to the **Covered Person** being covered under the dental benefit plan**.**, **Delta Dental** will make monthly payments of one fourteenth ($1/14^{th}$) of the balance that remains, based upon the monthly calculation described above. Monthly payments will stop at the earlier of the completion of the **Dental Services** or the date when the person is no longer a **Covered Person**.

(d) In the event that a **Covered Person** transfers from the care of one **Dentist** to that of another **Dentist** during a course of treatment, or if more than one **Dentist** renders services for the same dental **Procedure**, **Delta Dental** shall not be liable for more than the amount it would have been liable had but one **Dentist** rendered all these services during each course of treatment, nor shall **Delta Dental** be liable for duplication of services rendered.

Section 13- If You Have Coverage Through Another Plan-Coordination and Non-Duplication of Benefits

1. APPLICABILITY

This Coordination and Non-Duplication of Benefits provision applies to this Plan when a **Covered Person** has dental care coverage under more than one Plan. A **Covered Person** may be covered for dental benefits or services by more than one Plan. For instance, he or she may be covered through the employer's dental benefit **Plan** as an employee and by another Plan as a **Dependent** of his or her **Spouse**. If he or she is covered by more than one Plan, this provision allows **Delta Dental** to coordinate what it pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary Plan and which is the secondary Plan. When this Plan is secondary, it will pay a reduced benefit which, when added to the benefits paid by all other plans, will not exceed what it would have paid had it been the primary plan. No plan will pay more than it would have paid in the absence of this provision. Coordination and Non-Duplication of Benefits provision is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the **Covered Person** is covered. For coordination of benefits, your group follows the **Birthday Rule**.

2. DEFINITIONS

The words shown below have special meanings when used in this Section 15. Please read these definitions carefully.

(a) "Allowable Expense" means the charge for any **Dental Service** for which the **Covered Person** is liable when the **Dental Service** is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

Since the dental benefit plan provides benefits for **Dental Services**, it will coordinate benefits only with a Plan that also provides benefits for **Dental Services**.

When the dental benefit plan**t** is Coordinating Benefits with a Plan that restricts Coordination of Benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which Coordination of Benefits applies as an Allowable Expense.

(b) "Claim Determination Period" means a **Calendar Year**, or any portion of a **Calendar Year**, during which a **Covered Person** is covered by the dental benefit plan and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

"Plan" means coverage with which Coordination of Benefits is allowed.

i) Plan includes:
   1) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
   2) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;

3) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
4) Group hospital indemnity benefit amounts that exceed $ 150.00 per day;
5) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

ii) Plan does not include:
1) Individual or family insurance contracts or subscriber contracts;
2) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
3) Group or group-type coverage where the cost of coverage is paid solely by the **Covered Person** except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
4) Group hospital indemnity benefit amounts of $ 150.00 per day or less;
5) School accident-type coverage;
6) A State plan under Medicaid.

(c) "Primary Plan" means a Plan whose benefits for a **Covered Person's Dental Services** must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "i" or "ii" below exist:

i) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
ii) All Plans which cover the **Covered Person** use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

(d) "Reasonable and Customary" means an amount that is not more than the usual or customary charge for the service or supply as determined by a Plan, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

(e) "Secondary Plan" means a Plan which is not a Primary Plan. If a **Covered Person** is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

3. PRIMARY AND SECONDARY PLAN

Delta Dental considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration

the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically or Dentally necessary and appropriate services on the basis that Prior Authorization was not obtained.

4. RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the **Covered Person** as a **Dependent**. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the **Covered Person** as an employee who is neither laid off nor retired, or as a **Dependent** of such person, shall be determined before those for the Plan that covers the **Covered Person** as a laid off or retired employee, or as such a person's **Dependent**. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the **Covered Person** as an employee, member, subscriber or retiree, or **Dependent** of such person, shall be determined before those of the Plan that covers the **Covered Person** under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

i) The benefits of the Plan of the parent whose birthday falls earlier in the **Calendar Year** shall be determined before those of the parent whose birthday falls later in the **Calendar Year**.

ii) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.

iii) "Birthday," as used above, refers only to month and day in a **Calendar Year**, not the year in which the parent was born.

iv) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the **Bitewing** in this provision shall be ignored.

If a child is covered as a **Dependent** under Plans through both parents, and the parents are separated or divorced, the following rules apply:

i) The benefits of the Plan of the parent with custody of the child shall be determined first.
ii) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
iii) The benefits of the Plan of the parent without custody shall be determined last.
iv) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

5. PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which **Procedure** to follow it is necessary to consider:

i) The basis on which the Primary Plan and the Secondary Plan pay benefits; and
ii) Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the **Covered Person** may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R & C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the **Covered Person** may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the **Covered Person** uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per **Covered Person**. The **Covered Person** is liable only for the applicable deductible, coinsurance or copayment. If the **Covered Person** uses the services of

a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

i) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the **Covered Person** shall not exceed the fee schedule of the Primary Plan. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the **Covered Person** receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is R & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

i) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The **Covered Person** shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the **Covered Person** has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the **Covered Person** be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan

If the **Covered Person** receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

i) The amount of any deductible, coinsurance or copayment required by the Primary

Plan; or

ii) The amount the Secondary Plan would have paid if it had been the Primary Plan.

A. OTHER PROVISIONS REGARDING PAYMENT

1. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. **Delta Dental** has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. **Delta Dental** need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give **Delta Dental** any facts it needs to make a **Benefit** payment.

Section 14 - Where Do I Call/E-mail for Information?

Question	Phone Number	E-mail Address
Customer Service	800-452-9310	service@deltadentalnj.com
Obtain **Claim Forms**	800-452-9310	service@deltadentalnj.com
Explanation of Benefits	800-452-9310	service@deltadentalnj.com
Status of a claim	800-452-9310	service@deltadentalnj.com
Eligibility information	800-452-9310	service@deltadentalnj.com
Benefits information	800-452-9310	service@deltadentalnj.com
Completing the **Claim Form**	800-452-9310	service@deltadentalnj.com
Participating Dentist list	800-452-9310	www.deltadentalnj.com

Section 15 - Notice of Nondiscrimination and Accessibility Rights

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

We offer free aids and services to provide access to information. This includes information provided in other formats and languages.

If you need a qualified interpreter, information in another language, or information in another format, contact our Customer Service department at -800-452-9310 or by email at service@deltadentalnj.com.

TDD Line - a hearing-impaired member can call 1-800-246-1020, Monday through Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST and be connected with a TDD machine to also access our Customer Service agents.

If you believe that **Delta Dental** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you may file a grievance with **Delta Dental's** Compliance Office by mail to: Delta Dental of New Jersey, Inc., Compliance Office, 1639 Route 10, Parsippany, NJ 07054, by phone at (866) 861-4716, or by email to: compliance@deltadentalnj.com.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Information on how to file a civil rights complaint is available at: www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

Complaints can be filed electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone to the following:

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

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

Section 16 - Benefit Determination and Appeal Process Summary

Introduction: The United States Department of Labor has adopted regulations governing claim adjudication and appeals for group health plans governed by ERISA. The claims and appeals procedures apply to all ERISA plans, whether insured ("risk") or self-funded ("ASO" or "ASC").

Below is the Delta Dental of New Jersey, Inc. ("**Delta Dental**") Benefit Determination and Appeal Process. The procedures apply to ERISA plans. **Delta Dental** is currently voluntarily applying these procedures to non-ERISA plans whenever feasible.

Applicability: This process applies to all ERISA plans for which **Delta Dental** provides coverage or administration. **Delta Dental** has also elected to apply this process to non-ERISA plans for which **Delta Dental** provides coverage on a risk basis.

Pre-treatment Estimate: This group dental plan **does not require** prior approval of **Dental Services**. Nonetheless, you or your treating **Dentist** may request a **Pre-treatment Estimate** to obtain advance information on the plan's possible coverage and benefits for services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan as of the date service is rendered and is subject to any applicable co-payment, **Waiting Periods**, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, **Delta Dental** shall notify you and the treating **Dentist** of the denial in writing, by issuing an **Explanation of Benefits** (sometimes referred to as an Adverse Benefit Determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. If an extension is necessary, **Delta Dental** shall notify you and the **Dentist** of the extension and the reason it is necessary within the original 30-day period. If an extension is taken because either you or the **Dentist** did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) why the claim was denied, including a reference to specific plan provisions on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A description of **Delta Dental's** claim informal appeal and formal appeal processes and the time limits applicable to the processes, including a statement of your right to bring a civil action under ERISA (if applicable).

Request for Informal Review

If you or the billing **Dentist** disagrees with **Delta Dental's** Adverse Benefit Determination, either may within sixty (60) days of the mailing date of the Adverse Benefit Determination deliver a request to **Delta Dental** for informal review of the Adverse Benefit Determination. The request for informal review must be sent to:

Delta Dental of New Jersey, Inc.
Attn: Correspondence Department
P.O. Box 15132
Little Rock, AR 72231

The request for a review must include the following:

- **Dentist's** name
- Office name, address and license number
- Member's name
- Member's I.D. number and date of birth
- Name and date of birth of the **Covered Person** for whom the **Dental Services** were provided
- The claim number
- The reason(s) why **Delta Dental** should change its first decision and the specific decision the responsible party is seeking.
- Any supplemental information or diagnostic materials relevant to the claim in question.

The procedure is also explained on the reverse side of the **Explanation of Benefits** form. **Delta Dental** will issue its decision on the Informal Review within 60 days after receipt of the Informal Appeal. You are not required to request informal review. Any appeal relating to the original decision or the Informal Appeals decision must be made within 240 days following the mailing date of the original Adverse Benefit Determination.

Request for Appeal of Adverse Benefit Determination: If you disagree with **Delta Dental's** Adverse Benefit Determination, you may appeal this determination to **Delta Dental** within 240 days following the mailing date of the original Adverse Benefit Determination. The appeal must be in writing and must state why it is believed that **Delta Dental's** benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. **Delta Dental's** review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Delta Dental's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an Adverse Benefit Determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment, **Delta Dental** shall consult with a **Dentist** who has appropriate training and experience in the pertinent field of dentistry and who is neither the person who made the initial claim denial nor the subordinate of such individual. **Delta Dental** shall provide upon request of the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: Delta Dental shall notify the claimant in writing of its decision on the Formal Appeal within 30 days of its receipt of the appeal, unless it determines that special circumstances require an extension of time for processing as detailed below. In such cases, written notice of the extension shall be furnished to the claimant prior to the end of the initial 30-day period. In no event shall such extension exceed a period of 60 days from the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which **Delta Dental** expects to render the determination on the appeal.

If **Delta Dental** upholds the Adverse Benefit Determination on appeal, the notice to the claimant shall include the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) for the Adverse Benefit Determination, with reference to specific plan provisions upon which the Adverse Benefit Determination, is based, whether a specific rule, guideline or protocol relied upon in making the Adverse Benefit Determination, and if so, that a copy will be provided free of charge upon request.

- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request
- Advice that options for further recourse or for obtaining information may include contacting the state regulatory agency or local U.S. Department of Labor office, or bringing a civil action under ERISA.

Limitations on Legal Action: You must timely file an Adverse Benefit Determination appeal and get **Delta Dental**'s decision as described above before commencing any legal proceeding challenging any Adverse Benefit Determination. In any event, no legal proceeding shall be brought against **Delta Dental** for any determination once 36 months have passed from the date of when **Dental Services** were performed.

Section 17 - Health Care Fraud

It is insurance fraud to submit false information to a plan in order to receive a **Benefit** or to obtain a larger payment than you or a **Dentist** are entitled to receive. False claims include submitting a claim for a service not actually rendered, misdescribing a service which was rendered, misrepresenting the amount of the fee the **Dentist** charged and intended to collect (including failing to disclose that the **Dentist** will waive all or part of the **Covered Person's** co-payment or coinsurance, using an incorrect date for the actual rendering of the dental service or allowing someone not eligible for or enrolled in the plan to use the dental benefit.

Insurance fraud hurts everyone because it reduces the funds available to pay **bona fide** claims and can result in the termination of benefit plans due to increased costs. It has severe criminal and civil consequences to those who participate in such activities or the preparation or submission of such claims. We urge all plan participants to refrain from submitting or participating in the submission of false claims and to contact us **Delta Dental** if you suspect that a false claim has been submitted.

Section 18 – Amendment or Termination of the Contract

In the event of termination of the contract between **Delta Dental** and the employer for any reason, notice of termination shall be provided by the employer to **Covered Persons**. **Delta Dental** will have no responsibility for providing you with notice of termination of the dental benefit plan.

In the event of termination of this contract, no **Covered Person** shall, on or after the date on which the termination takes effect, be entitled to any further **Benefit** payments under this **Delta**

Section 19 – Examination, Information and Records

Delta Dental may require oral examination of a **Covered Person** by a **Dentist** designated by **Delta Dental** as part of its **Claim** review or utilization review process as a condition precedent to making a **Benefit** payment hereunder. If such examination is requested of and refused by a **Covered Person**, **Delta Dental** may, without waiving any rights it may have, make payment to the **Dentist** in accordance with the terms of this **Delta Dental PPO – Fixed Copay Program** and the **Contract** between **Delta Dental** and the employer based upon available information.

As a condition precedent to making a **Benefit** payment hereunder, **Delta Dental** shall be entitled to receive from **Dentist**s, physicians, hospitals or other sources, to such extent as may be lawful, such information and records relating to examination of or treatment rendered to a **Covered Person** as may be required for the processing of such **Claims**.

Section 20 – Exculpation

All **Dental Services** paid for by **Delta Dental** shall be in accordance with the accepted dental practices in the community at the time, but **Delta Dental** shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any dental office or its employee or on the part of any **Dentist** or others engaged by him/her in the course of rendering **Dental Services** to any **Covered Person**. In no instance shall any **Dentist** rendering services be deemed an agent or employee of **Delta Dental**.

Section 21 – General Provisions and Notices

1. No action shall be maintainable against **Delta Dental** for any **Claims** by or on behalf of the employer, any **Covered Person**, or any **Dentist** unless brought within 12 months from the date of event on which the **Claim** is based.

2. Any notice given under this **Contract** shall be sufficient if given or made available to the employer, when addressed to it at its office stated herein; if given to **Delta Dental**, when addressed to it at 1639 10 East, Parsippany, NJ 07054 and faxed to 973-285-4139; or if given to a **Covered Person**, when sent or made available to the employer for delivery by the employer to said **Covered Person**. The employer shall notify **Delta Dental** of any change of address of employer or **Subscriber**.

3. If **Delta Dental** payment is obtained by or for any person who is not entitled thereto, **Delta Dental** shall have the right to recover such payment from the payee or other person benefiting therefrom.

4. Indemnity in the form of cash will not be paid by **Delta Dental** to any **Subscriber** except in payment for services for which **Delta Dental** was liable under the **Contract** at the time such services were completed. If the **Subscriber** entitled to such payment is no longer living or is a minor, such payment may be made to such person as may, in **Delta Dental's** sole discretion, be deemed entitled thereto, and the liability of **Delta Dental** shall be thereby discharged to the extent of such payment.

5. Except as expressly otherwise provided by law, the **Benefits** and payments hereunder are personal and not assignable.

6. **Claims** for **Dental Services** rendered by New Jersey licensed **Dentist**s or other persons acting pursuant to the applicable scope of practice authorized by law shall be made on the Attending **Dentist's** Statement forms as supplied by **Delta Dental**. Said forms may be obtained upon request to **Delta Dental** at P.O. Box 16354, Little Rock, AR 72231.

7. **Delta Dental** shall not be obligated to make payment for **Treatment Plans** submitted more than one year after the date of completion of the service.

Section 22- Frequently Asked Questions

- Do I need to have an assigned **Dentist**?

  No. This plan allows you to be treated by any licensed **Delta Dental PPO Dentist** of your choice.

- Do I need a referral to a specialist?

  You are not required to have a referral to a specialist if you or your **Dependents** require specialized care, as long as you receive services from a **Delta Dental PPO Dentist** and the service is a **Covered Service** listed in the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits.**

- Am I required to ask for a **Pre-Treatment Estimate** (pre-determination of benefits)?

  No. **Delta Dental** does not require you or your **Delta Dental PPO Dentist** to ask for a **Pre-Treatment Estimate** of benefits prior to treatment. If your **Delta Dental PPO Dentist** indicates the need for treatment with dental charges in excess of $300, we strongly recommended that you request an estimate of dental benefits before receiving the treatment. Both you and your **Delta Dental PPO Dentist** will receive a voucher from **Delta Dental** showing the estimated **Benefit** payment, including and the corresponding fixed co-payment amount that is your responsibility. Your **Dentist** then completes this voucher and submits it for payment when work has been completed. **Pre-Treatment Estimates** are only estimates and not a guarantee of payment. Payments of the approved services are subject to eligibility and **Benefit Limitations** at the time services are rendered.

- Do I need an ID card as proof of coverage when I visit a **Dentist**?

  If your employer has issued an identification card, you should show it to your **Dentist**. However, it is not required that a **Dentist** see an ID card before rendering treatment. An ID card does not verify active coverage. You or your **Dentist** may obtain your group number, current eligibility and benefit information by contacting **Delta Dental** at 1-800-452-9310 24 hours a day, 7 days a week.

- What if I have questions about my benefits?

  You can call **Delta Dental's** Customer Service Department at 1-800-452-9310 and speak to a representative Monday through Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST.

- How is a claim filed?

  A claim can be submitted in several ways. Your **Dentist** should complete a **Delta Dental Claim Form** or an ADA (American Dental Association) approved form. That form may be transmitted by the dental office electronically or by mail to: Delta Dental of New Jersey, P.O. Box 16354, Little Rock, AR 72231. The **Claim Form** may also be faxed to 1-800-324-7939. When your **Dentist** files **Claims** electronically through his or her computer, no **Claim Form** is required. This method also speeds processing time.

  At your option, you may file a claim directly with us. You may download a **Claim Form** from our web site www.deltadentalnj.com and submit the claim as well. The claim can also be faxed to 1-800-324-7939 or submitted by mail to: Delta Dental of New Jersey, P.O. Box 16354, Little Rock, AR 72231

  Each **Covered Person** must have his or her own claim filed separately from another family member's claim. Also, each different **Dentist** visited must submit a separate claim. However, an individual **Dentist** may submit a claim for payment and a **Pre-Treatment Estimate** on the same **Claim Form**.

- What must the **Claim Form** contain?

  The claim must contain the treating **Dentist**'s signature and either the **Covered Person**'s signature or a representation from the treating **Dentist** that the **Covered Person** has signed a written authorization for the **Dentist** to submit the claim. The claim must also name the patient, the specified date of service and fee charged, and request approval for payment of a specific treatment, service or product.

- When will **Delta Dental** communicate its benefit determination?

  Delta Dental will notify you of its benefit determination for urgent care **Claims** as soon as possible but not later than 72 hours after receipt of the claim, providing sufficient information was received. If the claim is not complete, then **Delta Dental** will notify you or your representative within 48 hours after receipt of the claim.

  Delta Dental will notify you of its benefit determination for post-service **Claims** within a reasonable period of time, but not later than 30 days after receipt of the claim. If **Delta Dental** needs to extend its decision another 15 days, it will notify you of the reason for the extension and estimated determination date prior to the initial 30-day period.

- What will **Delta Dental** do if there is an Adverse Benefit Determination?

  If the benefit determination is adverse, **Delta Dental** will notify you in writing. The notice will specify the reason(s), refer to the specific plan provision, guideline or protocol upon which the determination was based, describe any additional material or information needed

for you to complete the claim and explain why such documentation is necessary, and describe the initial appeal process and time limits. In addition, if the Adverse Benefit Determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- Is there a time limit for submitting dental **Claims**?

  Yes. In most cases, you or your **Dentist** have one full year from the date of service to submit your dental **Claims**. If there is coordination of benefits involved and **Delta Dental** is not the primary plan, you have one year from the date on which the primary carrier(s) issues a statement of benefits. If the claim is submitted after these time frames, then **Benefits** for the services will be denied and are not covered.

- What can I do if I am dissatisfied with the initial Adverse Benefit Determination?

  You can file a request for informal review within 60 days of the Adverse Benefit Determination. You would send it to:

  Delta Dental of New Jersey, Inc.
  Attn: Correspondence Department
  P.O. Box 15132
  Little Rock, AR 72231

  Your request must include the **Dentist's** name, office name, address and license number, the **Subscriber's** name, member ID number and date of birth, the patient's name, date of birth, the claim number, the reason(s) why **Delta Dental** should change its initial decision and the specific decision you are seeking, any relevant information or diagnostic materials, and/or a copy of the claim for the determination you are appealing. You must also sign the request.

  The person making the decision at **Delta Dental** will be a person who did not make the initial determination and who is not the subordinate of the initial reviewer. The decision-maker for a determination based in whole or in part on medical judgment will consult with a health care professional who has training and experience involved in medical judgment and who was not consulted in the earlier determination(s).

  If the benefit determination is adverse, the notice will specify the reason(s), refer to the specific plan provision, guide or protocol upon which the determination was based, inform you of your right to receive free of charge, upon request, all relevant documentation, and describe any voluntary, external appeal procedures as well as your right to bring civil (court) action. In addition, if the Adverse Benefit Determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- What can I do if I am dissatisfied with the informal appeal decision?

  You or your **Dentist** must request a formal review in writing within 240 days of receipt of the original Adverse Benefit Determination (whether or not you requested an informal review) and send it to:

  Delta Dental of New Jersey, Inc.
  Attn: Formal Appeals Department
  P.O. Box 15132
  Little Rock, AR 72231

  The request for a formal review must include the **Dentist's** name, office name, address and license number, the member's name, member ID number and date of birth, the patient's name, date of birth, the claim number, the reason(s) why **Delta Dental** should change its initial decision and the specific decision you are seeking, any relevant information or diagnostic materials, and/or a copy of the claim for the determination you are appealing. You must also sign the request.

  If the **Dentist** is authorized to act on your behalf, he/she must state that and include a DOL authorization form. **Delta Dental** will notify you in writing of its determination within 72 hours for urgent care **Claims**, and within 30 days for pre- and post-service **Claims**.

- How do eligible children attending college away from home find a **Delta Dental PPO Dentist**?

  A customized list of **Dentists** for a specific geographic location can be obtained by calling 1-800-452-9310. This list will be mailed or can be faxed in case of an emergency situation. Also, listings of **Delta Dental PPO Dentists** throughout the country are available on our web site at www.deltadentalnj.com.

- If I am not located in the same state as my employer's headquarters, where do I call?

  No matter where you are located in the country, you can still call the same toll-free number 1-800-452-9310 to reach our Customer Service Department, Monday through Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST.

- For more Frequently Asked Question please visit **Delta Dental's** web site at www.deltadentalnj.com.

Section 23 - Continuation of Coverage (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (**COBRA**), you and/or your eligible **Dependents** may have the right to elect to continue certain group health coverage which would otherwise end as a result of any of the following events:

- termination of employment for reasons other than gross misconduct;
- a reduction of your hours so that you or your **Dependents** no longer meet the Eligibility Requirements for coverage;
- your death;
- your legal separation or divorce;
- your child no longer qualifies as a **Dependent**.
- you or your spouse becomes entitled to Medicare.
- your becoming eligible under the Trade Adjustment Assistance Reform Act of 2002

If coverage is to continue, you and/or your eligible **Dependents** will be responsible for paying the contributions and fees required for that coverage. Please see your plan administrator for additional information about **COBRA**.

Section 24 - Glossary

Term	Definition
Allowed Amount	Means the fee amount used in calculating the **Benefit** for the given **Covered Service**. The **Benefit** may be less than the **Allowed Amount** due to **Benefit Limitations**. The **Allowed Amount** may be less than the **Approved Amount**.
Amalgam	A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.
Another Delta Dental Plan	Means a **Delta Dental** member company in a state other than New Jersey and/or a **Delta Dental** member company affiliate of such corporation.
Approved Amount	Means the total fee that the **Delta Dental PPO Dentist** has agreed to accept as payment in full for the **Dental Service** provided. It includes both **Delta Dental's Benefit Amount** and the **Covered Person's** fixed co-payment obligation. For **Dental Services** provided by a **Dentist** that is not in the **Delta Dental PPO Network,** as for example, a **Delta Dental Premier Dentist** or a **Non-Participating Dentist**s, it is the fee actually charged for the **Dental Services** provided, since this plan only provides benefits for services received from a **Delta Dental PPO Dentist** and provides no benefit for treatment or services received from a **Delta Dental Premier Dentist** or a **Non-Participating Dentist** unless the service is for an emergency in which case the **Benefit** will be limited to an emergency exam and palliative treatment with a maximum annual benefit payment of $300.
Benefit or **Benefit Amount**	The dollar amount which **Delta Dental** will pay under this **Delta Dental PPO – Fixed Copay Program** toward a **Covered Service**.
Benefit Charges	Means the amount of **Benefit** claim payments for **Covered Services** and treatments of **Covered Persons** under this **Delta Dental PPO – Fixed Copay Program.**
Benefit Limitations	Restrictions on the **Benefit Amounts** payable under this **Delta Dental PPO – Fixed Copay Program. Benefit Limitations** include the following: (a) the **Delta Dental PPO – Fixed Copay Program** amount;

(b) the Limitations and Specific Exclusions; and (c) the General Exclusions described in this **Booklet**.

Birthday Rule — A standard used for coordination of benefits stipulating that the primary payor of benefits for **Dependent** children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a **Calendar Year** is considered primary.

Bitewing — A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Booklet — **Booklet** means this document.

Calendar Year — For **Benefit** determinations based on a **Calendar Year**, this refers to the period of one year beginning with January 1 and ending December 31.

Claim — A request to **Delta Dental** to pay a **Benefit** under this **Delta Dental PPO – Fixed Copay Program.**

Claim Form — The form the **Dentist** must file with **Delta Dental** to request payment for services rendered.

COB — Coordination of Benefits. A process governed by contract or rules when benefits are available for Covered Services payable under more than one plan.

COBRA — Consolidated Omnibus Budget Reconciliation Act. A federal law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their **Dependents** who have had their health insurance coverage terminated or had another qualifying event that entitles them to continue coverage. Parallel state law provisions ("mini-COBRA") lay also apply to permit continuation under state law.

Completion Date — The date a **Covered Service** is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges if these are **Covered Services** under this **Delta Dental PPO – Fixed Copay Program.**

Most **Dental Services** are finished in one day. The **Completion Date** for multistage **Dental Services** is described in this **Booklet** in the section heading under Other Payment Rules that Affect the Coverage of This **Delta Dental PPO – Fixed Copay Program**.

Composite White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of **Amalgam**.

Comprehensive Means when a **Dental Service** is inclusive of a related **Dental Service**. For example: periodontal osseous surgery is the **Comprehensive Dental Service** as it includes not only a periodontal flap **Procedure** but also flap entry and closure.

Consultation A discussion between the patient and the **Dentist** where the **Dentist** offers professional advice for the proposed **Treatment Plan**.

Coverage Period Means the term of this dental benefit plan, in months, beginning on the **Coverage Effective Date** and ending on the **Coverage Expiration Date**, during which most covered **Dental Services** must be completed by the **Completion Date** as defined in this **Booklet** to be eligible for a **Benefit** under this dental benefit plan.

Covered Person Means the eligible **Subscriber** and **Dependents** (as defined and designated by employer and identified by employer to **Delta Dental**) for whom **Contract Charges** are being paid**.**. A **Covered Person** shall cease to be covered by this **Delta Dental PPO – Fixed Copay Program** at the point when such **Covered Person** ceases to meet the definition of **Subscriber** and/or **Dependent,** the employer notifies **Delta Dental** that the **Subscriber** and/or **Dependent** are no longer **Covered Persons,** or the **Contract** between employer and **Delta Dental** is terminated or expires.

Covered Services Are defined as **Dental Services** that are listed under Section heading - Description of Eligible Dental Services. **Covered Services** are eligible for payment of **Benefits** under this **Delta Dental PPO – Fixed Copay Program** if they are listed **Procedures** in the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits,** subject to all applicable **Benefit Limitations** and terms of contained in this **Booklet**.

Delta Dental®	Means Delta Dental of New Jersey, Inc.
Delta Dental Participating Dentist	A state-licensed **Dentist** who has a written agreement with a **Delta Dental** or **Another Delta Dental Plan** to perform services and receive payment under an applicable program. **Delta Dental Participating Dentists** include: **Delta Dental PPO Dentists** and **Delta Dental Premier Dentists.**
Delta Dental PPO™ Dentist	Means a **Dentist** who participates in the **Delta Dental PPO Network**. For purposes of this **Fixed Copay PPO Plan**, a **Delta Dental PPO Dentist** is considered in-network and only services received by a **Covered Person** from a **Delta Dental PPO Dentist** will be eligible for a **Benefit** payment in accordance with the terms of this **Booklet**. A **Delta Dental PPO Dentist** has an agreement in force with **Delta Dental** or, in states other than New Jersey, is a **Dentist** identified by **Another Delta Dental Plan** as a **Delta Dental PPO Dentist**. They are listed in the most recent Directory or listing of **Delta Dental PPO Dentists**. A **Delta Dental PPO Dentist** has agreed to perform eligible **Dental Services** and accepts payment from **Delta Dental** and the fixed co-payment from the **Covered Person** as listed in the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits** as payment in full. A **Delta Dental PPO Dentist** does not include a **Delta Dental Premier Dentist.**
Delta Dental Premier® Dentist	Means a **Dentist** who participates in the **Delta Dental Premier** network. For purposes of this **Delta Dental PPO – Fixed Copay Program,** a **Delta Dental Premier Dentist** is considered out-of-network and no **Benefit** will be paid for services received by a **Covered Person** from a **Delta Dental Premier Dentist** except for emergency services that is limited to an emergency exam and palliative treatment with a maximum annual **Benefit** payment of $300.
Dental Service(s)	Means dental treatment and related **Procedures** rendered by a **Dentist** or oral surgeon or other person duly licensed to render that treatment by the state in which they were rendered.
Dentist	Means a person duly licensed to practice **Dentistry** in the state in which the treatment is rendered.

Dentistry	Is defined as the evaluation, diagnosis, prevention and/or treatment (non-surgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a **Dentist**, or another person duly licensed to render that treatment by the state or country in which they were rendered within the scope of his/her education, training and experience.
Dependent	Is defined as each person who meets the criteria established by the employer. Persons in military service are not eligible to be **Dependents** under this dental benefits plan.
Excluded or **Exclusion**	Mean **Dental Services** and/or charges for which no **Benefit** is payable under this **Contract**.
General Dentist	A state-licensed **Dentist** who provides a full range of dental services for the entire family.
In Conjunction With	Means in close association with or as part of another episode of treatment including, but not limited to, being performed on the same day.
Non-Participating Dentist	Means a **Dentist** who is not a **Delta Dental Participating Dentist** and is neither in the **Delta Dental PPO Network** nor in the **Delta Dental Premier® network** A **Non-Participating Dentist** is a **Dentist** that does not have an agreement in place with **Delta Dental**.
PPO Network	Means the dental network that applies to this plan and the network that **Covered Persons** can use in order to receive benefits under this plan**.** For purposes of this plan, dentists that are in the Delta Dental Premier® network (**Delta Dental** Premier dentists**)** and dentists that do not participate in any **Delta Dental** network are considered "out-of-network," and, except for emergency services, no **Covered Person** will be entitled to any payment or receive a benefit for dental services received from an out-of-network dentist.
Pre-Treatment Estimate	Pre-authorized estimate of services detailing payment of allowable benefits.

Procedure Is defined to be a dental **Procedure** to which a separate procedure number has been assigned in the Procedure Code and Nomenclature List of the American Dental Association and which, if listed on the **Delta Dental PPO – Fixed Copay Program Schedule of Benefits,** is an eligible **Dental Service** under this dental benefit plan, as more fully described in Section heading – Description of Eligible Dental Services of this **Booklet**.

Prophylaxis Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a **Dentist** or dental hygienist.

Pro-rated If this Delta Dental PPO – Fixed Copay Program provides Benefits for orthodontic treatment, and treatment has already begun, Delta Dental's monthly Benefit may be calculated by dividing the cost of treatment by the number of months of treatment and multiplying that amount by the number of months that the Covered Person is covered under this Delta Dental PPO – Fixed Copay Program, taking into account the prior plan's payment and the applicable fixed dollar co-payment listed in the Delta Dental PPO – Fixed Copay Program Schedule of Benefits.

Sealant An adhesive material bonded to the tooth surface to retard decay by shielding the tooth from exposure to the oral environment. This includes preventive resin restorations.

Subscriber Is defined to be person who is the employee of the employer who is eligible for dental benefits under this **Delta Dental PPO – Fixed Copay Program** as provided in Section heading – Eligibility Requirements of this **Contract**. A "**Subscriber**" must also have been designated as a **Subscriber** to **Delta Dental** by the employer. Persons in military service are not eligible for **Benefits** under this **Fixed Copay PPO Plan.**

Treatment Plan Means the written statement, on a form (Attending **Dentist's** Statement) prescribed by **Delta Dental**, of diagnosis(es) or prognosis(es) and the course and types of care and treatment to be rendered by a **Dentist** to a **Covered Person** together with associated charges when such statement is signed by the **Dentist** and **Covered Person**. **Delta Dental** may, in its discretion, approve a **Treatment Plan** for payment of **Benefits** in whole or in part. **Delta Dental's** determination as to payment of **Benefits** under a **Treatment Plan** is final.

Notes:

P. O. Box 16354
Little Rock, AR 72231

800-452-9310

www.deltadentalnj.com

Everyone Deserves Good Oral Health.

SCHEDULE A -DESCRIPTION OF DENTAL BENEFITS and COPAYMENTS

Subject to the terms of the **Contract** and the limitations, exclusions and **Covered Person** copayments listed below, the following services may be eligible for **Benefit**s under the **Contract**. **Covered Persons should discuss all treatment options with their Dentist prior to services being rendered.**

The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

	Delta Dental PPO – Fixed Copay Program	Enrollee Copayments Complete
D0100-D0999	**DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation - post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source and detector	$0
D0251	Extraoral posterior dental radiographic image	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0321	Other temporomandibular joint films, by report	$0
D0330	Panoramic radiographic image	$0
D0364	Cone beam CT capture and interpretation with limited field of view - less than whole jaw	$0
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$0
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$0
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	$0
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	$0

D0415	Collection of microorganisms for culture and sensitivity	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D1000-D1999	**PREVENTIVE**	
D1110	Prophylaxis cleaning - adult	$0
D1120	Prophylaxis cleaning - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1353	Sealant repair - per tooth	$0
D1354	Interim caries arresting medicament application	$0
D1510	Space maintainer - fixed – unilateral	$0
D1516	Space maintainer - fixed - bilateral, maxillary	$0
D1517	Space maintainer - fixed - bilateral, mandibular	$0
D1520	Space maintainer - removable – unilateral	$0
D1526	Space maintainer - removable - bilateral, maxillary	$0
D1527	Space maintainer - removable - bilateral, mandibular	$0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$0
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$0
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$0
D1556	Removal of fixed unilateral space maintainer - per quadrant	$0
D1557	Removal of fixed bilateral space maintainer - maxillary	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	$0
D1575	Distal shoe space maintainer - fixed – unilateral	$0
D2000-D2999	**RESTORATIVE**	
D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$0
D2331	Resin-based composite - two surfaces, anterior	$0

D2332	Resin-based composite - three surfaces, anterior	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$0
D2391	Resin-based composite - one surface, posterior	$0
D2392	Resin-based composite - two surfaces, posterior	$0
D2393	Resin-based composite - three surfaces, posterior	$0
D2394	Resin-based composite - four or more surfaces, posterior	$0
D2510	Inlay - metallic - one surface	$0
D2520	Inlay - metallic - two surfaces	$0
D2530	Inlay - metallic - three or more surfaces	$0
D2542	Onlay - metallic - two surfaces	$0
D2543	Onlay - metallic - three surfaces	$0
D2544	Onlay - metallic - four or more surfaces	$0
D2610	Inlay - porcelain/ceramic - one surface	$0
D2620	Inlay - porcelain/ceramic - two surfaces	$0
D2630	Inlay - porcelain/ceramic - three or more surfaces	$0
D2642	Onlay - porcelain/ceramic - two surfaces	$0
D2643	Onlay - porcelain/ceramic - three surfaces	$0
D2644	Onlay - porcelain/ceramic - four or more surfaces	$0
D2650	Inlay - resin-based composite - one surface	$0
D2651	Inlay - resin-based composite - two surfaces	$0
D2652	Inlay - resin-based composite - three or more surfaces	$0
D2662	Onlay - resin-based composite - two surfaces	$0
D2663	Onlay - resin-based composite - three surfaces	$0
D2664	Onlay - resin-based composite - four or more surfaces	$0
D2710	Crown - resin-based composite (indirect)	$0
D2712	Crown - ¾ resin-based composite (indirect)	$0
D2720	Crown - resin with high noble metal	$0
D2721	Crown - resin with predominantly base metal	$0
D2722	Crown - resin with noble metal	$0
D2740	Crown - porcelain/ceramic substrate	$0
D2750	Crown - porcelain fused to high noble metal	$0
D2751	Crown - porcelain fused to predominantly base metal	$0
D2752	Crown - porcelain fused to noble metal	$0
D2780	Crown - ¾ cast high noble metal	$0
D2781	Crown - ¾ cast predominantly base metal	$0
D2782	Crown - ¾ cast noble metal	$0
D2783	Crown - ¾ porcelain/ceramic	$0
D2790	Crown - full cast high noble metal	$0
D2791	Crown - full cast predominantly base metal	$0
D2792	Crown - full cast noble metal	$0
D2794	Crown – titanium	$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0

D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$0
D2921	Reattachment of tooth fragment, incisal edge or cusp (anterior)	$0
D2929	Prefabricated porcelain/ceramic crown - primary tooth - anterior	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2932	Prefabricated resin crown - anterior primary tooth	$0
D2933	Prefabricated stainless steel crown with resin window - anterior primary tooth	$0
D2934	Prefabricated esthetic coated stainless steel crown-primary tooth	$0
D2940	Placement of interim direct restoration	$0
D2941	Interim therapeutic restoration - primary dentition	$0
D2949	Restorative foundation for an indirect restoration	$0
D2950	Core buildup, including any pins when required	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated - includes canal preparation	$0
D2953	Each additional indirectly fabricated post - same tooth - includes canal preparation	$0
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	$0
D2957	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$0
D2980	Crown repair necessitated by restorative material failure	$0
D2981	Inlay repair necessitated by restorative material failure	$0
D2982	Onlay repair necessitated by restorative material failure	$0
D2983	Veneer repair necessitated by restorative material failure	$0
D2990	Resin infiltration of incipient smooth surface lesions	$0
D3000-D3999	**ENDODONTICS**	
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$0
D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration)	$0

D3330	Root canal - endodontic therapy, molar (excluding final restoration)	$0
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal root repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$0
D3347	Retreatment of previous root canal therapy - bicuspid	$0
D3348	Retreatment of previous root canal therapy - molar	$0
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$0
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3410	Apicoectomy – anterior	$0
D3421	Apicoectomy - bicuspid (first root)	$0
D3425	Apicoectomy - molar (first root)	$0
D3426	Apicoectomy (each additional root)	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$0
D3471	Surgical repair of root resorption - anterior	$0
D3472	Surgical repair of root resorption – premolar	$0
D3473	Surgical repair of root resorption – molar	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$0
D4000-D4999	**PERIODONTICS**	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$0
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$0
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$0
D4245	Apically positioned flap	$0
D4249	Clinical crown lengthening - hard tissue	$0
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$0
D4263	Bone replacement graft - retained natural tooth –first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth –each additional site in quadrant	$0

D4270	Pedicle soft tissue graft procedure	$0
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	$0
D4274	Mesial/distal, wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous tooth position in graft	$0
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	$0
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$0
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$0
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$0
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$0
D4910	Periodontal maintenance	$0
D4921	Gingival irrigation - per quadrant	$0
D5000-D5899	**PROSTHODONTICS (removable)**	
D5110	Complete denture – maxillary	$0
D5120	Complete denture – mandibular	$0
D5130	Immediate denture – maxillary	$0
D5140	Immediate denture – mandibular	$0
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$0
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$0
D5222	Immediate mandibular partial denture – resin base (including conventional clasps, rests and teeth)	$0
D5223	Immediate maxillary partial denture – cast metal frameworks with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5224	Immediate mandibular partial denture – cast metal frameworks with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$0
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$0
D5282	Removable unilateral partial denture - one piece cast metal (including	$0

	retentive/clasping materials, rests, and teeth), maxillary	
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$0
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5511	Repair broken complete denture base, mandibular	$0
D5512	Repair broken complete denture base, maxillary	$0
D5520	Replace missing or broken teeth - complete denture - per tooth	$0
D5611	Repair resin partial denture base, mandibular	$0
D5612	Repair resin partial denture base, maxillary	$0
D5621	Repair cast partial framework, mandibular	$0
D5622	Repair cast partial framework, maxillary	$0
D5630	Repair or replace broken clasp per tooth	$0
D5640	Replace missing or broken teeth - partial denture - per tooth	$0
D5650	Add tooth to existing partial denture - per tooth	$0
D5660	Add clasp to existing partial denture per tooth	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0
D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (laboratory)	$0
D5751	Reline complete mandibular denture (laboratory)	$0
D5760	Reline maxillary partial denture (laboratory)	$0
D5761	Reline mandibular partial denture (laboratory)	$0
D5820	Interim partial denture (maxillary)	$0
D5821	Interim partial denture (mandibular)	$0
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D6200-D6999	**PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge))**	
D6210	Pontic - cast high noble metal	$0
D6211	Pontic - cast predominantly base metal	$0
D6212	Pontic - cast noble metal	$0
D6214	Pontic - titanium and titanium alloys	$0
D6240	Pontic - porcelain fused to high noble metal	$0
D6241	Pontic - porcelain fused to predominantly base metal	$0

D6242	Pontic - porcelain fused to noble metal	$0
D6245	Pontic - porcelain/ceramic	$0
D6250	Pontic - resin with high noble metal	$0
D6251	Pontic - resin with predominantly base metal	$0
D6252	Pontic - resin with noble metal	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$0
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$0
D6549	Resin retainer - for resin bonded fixed prosthesis	$0
D6600	Inlay - porcelain/ceramic, two surfaces	$0
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$0
D6602	Retainer inlay - cast high noble metal, two surfaces	$0
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$0
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$0
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$0
D6606	Retainer inlay - cast noble metal, two surfaces	$0
D6607	Retainer inlay - cast noble metal, three or more surfaces	$0
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$0
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$0
D6610	Retainer onlay - cast high noble metal, two surfaces	$0
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$0
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$0
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$0
D6614	Retainer onlay - cast noble metal, two surfaces	$0
D6615	Retainer onlay - cast noble metal, three or more surfaces	$0
D6720	Retainer crown - resin with high noble metal	$0
D6721	Retainer crown - resin with predominantly base metal	$0
D6722	Retainer crown - resin with noble metal	$0
D6740	Retainer crown - porcelain/ceramic	$0
D6750	Retainer crown - porcelain fused to high noble metal	$0
D6751	Retainer crown - porcelain fused to predominantly base metal	$0
D6752	Retainer crown - porcelain fused to noble metal	$0
D6780	Retainer crown - ¾ cast high noble metal	$0
D6781	Retainer crown - ¾ cast predominantly base metal	$0
D6782	Retainer crown - ¾ cast noble metal	$0
D6783	Retainer crown - ¾ porcelain/ceramic	$0
D6790	Retainer crown - full cast high noble metal	$0
D6791	Retainer crown - full cast predominantly base metal	$0
D6792	Retainer crown - full cast noble metal	$0
D6794	Retainer crown - titanium and titanium alloys	$0
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY

D7111	Extraction, coronal remnants - primary tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$0
D7220	Removal of impacted tooth - soft tissue	$0
D7230	Removal of impacted tooth - partially bony	$0
D7240	Removal of impacted tooth - completely bony	$0
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$0
D7250	Removal of residual tooth roots (cutting procedure)	$0
D7251	Coronectomy - intentional partial tooth removal	$0
D7260	Oroantral fistula closure	$0
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$0
D7280	Exposure of an unerupted tooth	$0
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$0
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$0
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	$0
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty — ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty — ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7410	Excision of benign lesion up to 1.25 cm	$0
D7411	Excision of benign lesion greater than 1.25 cm	$0
D7440	Excision of malignant tumor up to 1.25	$0
D7441	Excision of malignant tumor greater than 1.25 cm	$0
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$0
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$0
D7460	Removal of nonodontogenic cyst or tumor lesion diameter up to 1.25 cm	$0
D7461	Removal of nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm	$0
D7465	Destruction of lesion(s) by physical or chemical method, by report	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$0
D7472	Removal of torus palatines	$0
D7473	Removal of torus mandibularis	$0

D7485	Surgical reduction of osseous tuberosity	$0
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7511	Incision and drainage of abscess — intraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	$0
D7520	Incision and drainage of abscess extraoral soft tissue	$0
D7521	Incision and drainage of abscess extraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	$0
D7530	Removal of foreign bodies	$0
D7540	Removal of reaction bodies	$0
D7550	Removal of non-vital bone partial ostectomy/sequestrectomy	$0
D7961	Buccal/labial frenectomy (frenulectomy)	$0
D7962	Lingual frenectomy (frenulectomy)	$0
D7963	Frenuloplasty	$0
D7970	Excision of hyperplastic tissue - per arch	$0
D7971	Excision of pericoronal gingiva	$0
D9000-D9999	**ADJUNCTIVE GENERAL SERVICES**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Local anesthesia in conjunction with operative or surgical procedures	$0
D9222	Deep sedation/general anesthesia — first 15 minutes	$0
D9223	Deep sedation/general anesthesia — each subsequent 15-minute increment	$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$0
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$0
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$0
D9248	Non-intravenous conscious sedation	$0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9932	Cleaning and inspection of removable denture, maxillary	$0
D9933	Cleaning and inspection of removable complete denture, mandibular	$0
D9934	Cleaning and inspection of removable partial denture, maxillary	$0
D9935	Cleaning and inspection of removable partial denture, mandibular	$0
D9940	Occlusal guard, by report	$0
D9941	Fabrication of athletic mouthguard	$0
D9943	Occlusal guard adjustment	$0
D9951	Occlusal adjustment, limited	$0
D9952	Occlusal adjustment, complete	$0
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$0

SCHEDULE B -DESCRIPTION OF DENTAL BENEFITS and COPAYMENTS

Subject to the terms of the **Contract** and the limitations, exclusions and **Covered Person** copayments listed below, the following services may be eligible for **Benefit**s under the **Contract**. **Covered Persons should discuss all treatment options with their Dentist prior to services being rendered.**

The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

ADA CODE	PROCEDURE DESCRIPTION	Covered Person Copayments
D8000-D8999	**ORTHODONTICS**	
D8070	Comprehensive Orthodontic Treatment- Transitional Dent	$0
D8080	Comprehensive Orthodontic Treatment- Adolescent Dent	$0
D8090	Comprehensive Orthodontic Treatment-- Adult Dentition	$0
D8999	Unspecified Orthodontic Procedure, by report	$0