

Dental Alliance Participation Agreement

In order to receive a Master Group Contract evidencing dental benefit coverage for the undersigned New Jersey public employer group for its eligible public employees and their eligible dependents for group dental benefits underwritten by Delta Dental of New Jersey, Inc., a New Jersey Dental Service Corporation, each public employer member of the Alliance shall request participation in the Alliance. If the administrator approves the public employer group for participation in the Alliance, it shall refer the public employer to Delta Dental of New Jersey, Inc. which shall then issue a Master Group Contract to each individual public employer group to evidence that the undersigned, as of the effective date listed in the Master Group Contract, is entitled to receive dental benefit coverage subject to the terms, conditions, limitations, and premium as set forth in the terms of the Master Group Contract issued by Delta Dental of New Jersey, Inc. The undersigned New Jersey public employer group acknowledges that the premium amounts payable to Delta Dental of New Jersey, Inc., include a fee in the amount of 2.5% of premium to be paid by Delta Dental of New Jersey, Inc. to the administrator of the Alliance as compensation for its activities relative to the Alliance.

The undersigned acknowledges and agrees to be bound by the Master Group Contract, as amended from time to time, and further agrees to the following as a member of the Alliance: (a) to furnish information that the Alliance administrator or Delta Dental of New Jersey, Inc. requests for the proper administration of the Alliance or the Master Group Contract; (b) that it has no right, title, or interest in or to the premium monies or fees remitted by any other Alliance member; (c) that each member of the Alliance shall be issued its own Master Group Contract based on the plan design selected by the individual public employer on policy forms provided by Delta Dental of New Jersey, Inc.; (d) the initial premium rate for each member of the Alliance for the effective date listed in the Master Group Contract shall be determined by Delta Dental of New Jersey, Inc.

consistent with its current rating formula for Alliance members; (e) premium adjustments for each member of the Alliance upon renewal (after the initial 12 month premium rate) shall be “pooled” based on the collective experience of all of the public employer group participants of the Alliance, as adjusted for the plan design selected by each individual public employer group Alliance participant; (f) the Alliance shall not impose any risk sharing between or among the public employer group participants of the Alliance; (g) dental benefits payable under the Master Group Contract are governed solely and exclusively by the terms and conditions of the Master Group Contract issued to the respective member of the Alliance for benefits determined by Delta Dental of New Jersey, Inc.; (h) the Alliance administrator has no rights or obligations under any Master Group Contract other than to assist in the “pooling” of the premium adjustments referenced in (e); (i) each member of the Alliance shall be responsible for making its own required premium payments directly to Delta Dental of New Jersey, Inc.; (j) failure by the undersigned to remit premium amounts when due authorizes the Alliance administrator to terminate participation of the undersigned from the Alliance and authorizes Delta Dental of New Jersey, Inc. to terminate the Master Group Contract and cancel benefits thereunder; (k) Delta Dental of New Jersey, Inc.’s responsibilities and obligations shall be governed by the terms of the Master Group Contract and nothing in this Dental Alliance Participation Agreement or a public employer group’s membership or participation in this Alliance shall give rise to a cause of action against Delta Dental of New Jersey, Inc. other than claims relating to compliance with the terms of the member’s Master Group Contract, (l) the undersigned may withdraw from the Alliance and terminate coverage under the Master Group Contract by providing written notice both to the Alliance administrator and to Delta Dental of New Jersey, Inc. 60 days prior to expiration of the Master Group Contract to be effective at expiration of the Master Group Contract; (m) no public employer group that is a member of the Alliance shall be charged a penalty for its withdrawal from the Alliance or terminating coverage under the Master Group Contract in accordance with the terms of the Master Group Contract issued


by Delta Dental of New Jersey, Inc.; (n) individual member claim experience will be made available to the member of the Alliance consistent with all applicable state and federal privacy laws in the event a renewal increase exceeds the greater of 7% or dental industry trend.

The undersigned is authorized to execute this Alliance Participation Agreement for a benefit effective date of 7/1/25. The undersigned acknowledges that the Master Group Contract issued by Delta Dental of New Jersey, Inc. shall govern the benefit effective date.

Employer Name: Glassboro Board of Education
Employer Address: 560 Joseph L Bowe Blvd Glassboro, NJ 08028
Employer Authorized Representative: Michael Sloan
Title: Business Administrator
Signature: _____
Date: _____

ACCEPTED BY:

Dental Alliance, LLC. (Administrator)

By: 
Name: Richard S. Allen
Date: 5/12/25



Dental Benefits Solution

Delta Dental of New Jersey, Inc.

Presented by: Stanley H. Allen, Inc.

For: Borough of Glassboro Board of Education

Effective date: July 01, 2025

Mark Sainato

Sales Executive

Telephone: 201-919-5651

Email: msainato@deltadentalnj.com

Delta Dental of New Jersey, Inc

1639 Route 10

Parsippany, NJ 07054

DeltaDentalNJ.com



Delta Dental Gives You Many Reasons to Smile

As the largest national dental network,¹ our flexible dental and vision benefit plans are customized to meet your needs, resulting in measurable cost savings for your oral health needs. Friendly and efficient service is provided by our locally based customer service team, experienced dental professionals on staff, and an account management team that works for you.

Dental Benefits, Oral Health, and Vision are Our Focus

1. **Delta Dental was founded by business leaders and dentists in 1954.** These early visionaries believed that dental benefits could improve people's oral and overall health.
2. **That philosophy still drives us.** We believe sticking with strong benefit designs and best-in-class service delivers the greatest value with no surprises.
3. **We focus on oral health, wellness, and vision** as only a stand-alone dental carrier can, and now offer a best in class vision solution through our partner, VSP.



We Keep Your Smiles Healthy

Over 85 million Americans trust Delta Dental to help keep their smiles healthy.² Trust us to do the same for your group.

Plan Sponsors Choose and Stay with Us

Delta Dental of New Jersey first started offering dental programs in 1969. Many of our groups and their covered members have been with us for decades. Our high retention rates (95+%) speak for themselves.



We Are The Market Leader

Nationally, we are the largest dental network and insure more Americans than any other dental carrier. As New Jersey's leading dental benefits company, we provide or administer coverage to more than 1.9 million people through contracts with groups in New Jersey and Connecticut.³

Thank you for the opportunity to present our proposal.

Please read on to learn how Delta Dental will keep everyone in your group smiling.

¹ Delta Dental Plans Association 2022 Fact Sheet

² Delta Dental Plans Association 2022 Fact Sheet

³ Delta Dental Internal Data



Our Dental Networks Add Up to More Smiles

Delta Dental members are more likely to see a participating dentist, providing protection against balance billing.



4 out of 5 Dentists Nationwide Participate with Delta Dental



86% of Dentists in New Jersey Participate



100% Dentist Credentialing In-House

We Count Dentists, Not Access Points

Size matters; every dentist in our network means an actual dentist, not a building or location. Since we also own our networks, our members enjoy more stability with their dentists, making it easier for members to stay in-network. This means significant savings and a great customer experience for both groups and members!

Our National Networks:

Delta Dental PPO™ A network with deeper discounts

Delta Dental Premier® A network with broader access and impressive discounts

DeltaCare® USA A managed DHMO network

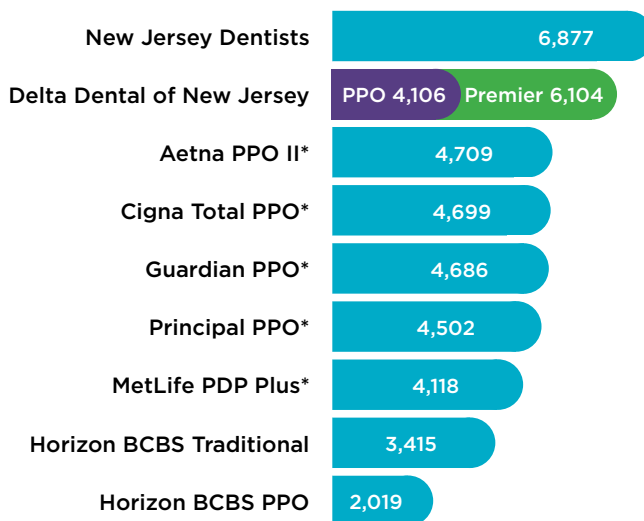
MAC vs UCR

- Our MAC plan keeps over 90% of claims in-network with NO balance billing of any kind.
- Your calendar year max goes further with a Delta Dental MAC plan and network strength than with a competitor's UCR plan and weaker network.
- Network discounts matter only when members stay in network. Low in-network participation levels negate a network's discount.
- Medical plans don't allow UCR. Why should dental plans?
- Bottom line: MAC plans drive members in-network, saving both the employer and member money while delivering value for their benefit dollars.



Compare Our Network Strength vs. Other Carriers

New Jersey Network Comparison¹



*Lease or swap arrangements compose a significant portion of the carrier's network, resulting in the potential for hidden network access fees and network instability when arrangements terminate.

As of January 2023; Delta Dental and Network360 data.

Spreading Smiles with our “Safety Net”

In-network dentists have agreed to pre-established fees for covered services. Members can choose any dentist, at any time, but will receive significant savings when using a Delta Dental participating PPO or Premier network dentist. Members are encouraged to use the PPO network to receive the greatest savings. And, the Premier network offers exceptional access while providing a safety net protecting members from unexpected out-of-network balance billing.

Combined, These Networks Provide One Powerful Package



● **94%** in-network utilization

- PPO Network
- Premier Network
- Out-of-Network



Other carriers

● **60%** in-network utilization

- Out-of-Network
- Would be in-network with Delta Dental



¹ National stats based on locations that have been validated with recent claims data (practicing locations, not all locations).



Flexible Programs and Features for Healthy Smiles and Happy Members

Dental benefits encourage patients to visit the dentist for regular exams and cleanings. Often these visits are at no cost to the patient and may help identify, prevent, and control potentially serious health conditions. We build the right program for your business using our dental benefits expertise and the most advanced evidence-based plan research available. Optional no-cost or low-cost benefit enhancements include:



Oral Health Enhancement

Additional cleanings and maintenance procedures for members treated for periodontal disease.



Carryover MaxSM

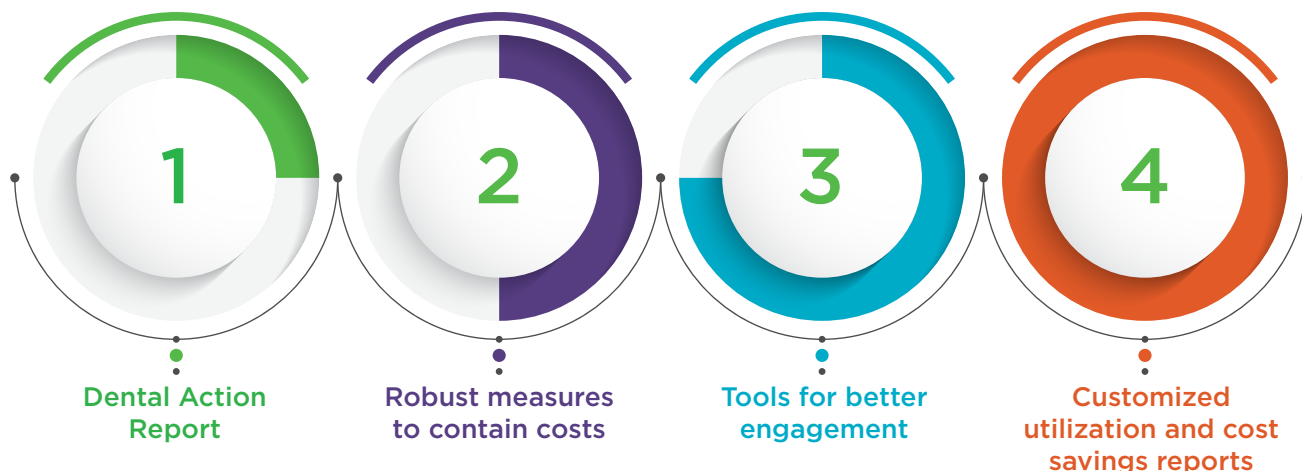
Members are able to carry over a portion of their unused annual maximum for future covered procedures—even from their previous carrier. Speak with your Delta Dental Account Executive to learn more.



Integrated Oral Health

Provides additional benefits for members diagnosed with cardiovascular disease and diabetes, as well as for pregnant women.

“Extras” Mean More Smiles, Value, and Benefits—Not More Money





Nation's Largest Dental Network Means More Choice, More Savings

No one can match the size or scope of our combined Delta Dental Premier® and Delta Dental PPO™ network. With a Delta Dental PPO Plus Premier™ plan, members gain access to dentists in two networks. This combination creates one powerful program to maximize in-network savings.

Here's how Delta Dental PPO Plus Premier works

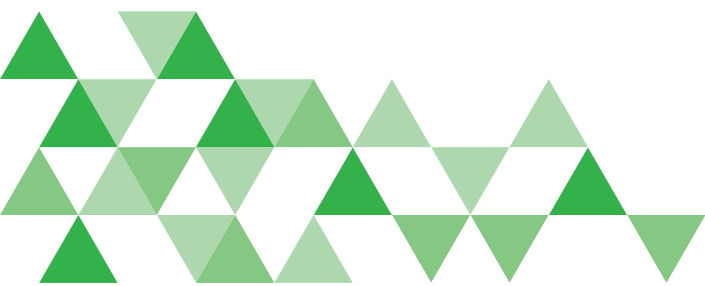
1. Members can choose any dentist (in-network or out).
2. Members receive significant savings when using a participating Delta Dental dentist.
 - Our PPO network offers members the greatest savings and the lowest out-of-pocket costs. Plus, there's no balance billing for the difference between the dentist's charge and allowed amount.
 - Our Premier network offers members the greatest access to participating dentists and lower out-of-pocket costs. Plus, there's no balance billing for the difference between the dentist's charge and allowed amount.
 - Out-of-network dentists can still be used, but members will pay more out-of-pocket costs. Plus, dentists can balance the bill for the difference between their charge and what Delta Dental pays them.

There's one more benefit

Delta Dental has negotiated discounted fees with participating dentists, so even when members pay out of pocket for some services, they pay less than if they didn't have coverage. For example, choosing a PPO Plus Premier participating dentist saves you more out-of-pocket when getting a crown:

Getting a Crown						
	Dentist's charge	Sample Delta Dental fees	Co-payment	Delta Dental Pays	Balance billed amount	Amount you pay out of pocket
PPO Network	\$1,438	\$790	50%	\$395	\$0	\$395 (\$790 - \$395)
Premier Network	\$1,438	\$930	50%	\$465	\$0	\$465 (\$930 - \$465)
Non-participating	\$1,438	\$790	50%	\$395	\$648	\$1,043 (\$1,438 - \$395)

For illustrative purposes only. Fees vary by procedure and location.





Delta Dental PPO Plus Premier: Benefits that members actually use

With any benefit plan, members must see participating providers to take full advantage of plan savings. What other carriers may not tell you is that many of their members end up going out of network because their dentists aren't in the plan.

Low in-network utilization means your members spend more of their money for care—and that won't make them happy.

With Delta Dental PPO Plus Premier™, more than 9 out of 10 members see in-network dentists—maximizing their benefits and minimizing their out-of-pocket costs.



Suppose you want to go for your regular preventive and diagnostic dental appointment. We pay 100% of an **allowed** amount—the amount our participating dentists agree to accept, which is less than what they charge their out-of-network patients. Below are some examples:

Regular Preventive and Diagnostic Visit						
	Dentist's charge	Sample Delta Dental fees	Co-payment	Delta Dental Pays	Balance billed amount	Amount you pay out of pocket
PPO Network	\$270	\$140	0%	\$140	\$0	\$0
Premier Network	\$270	\$160	0%	\$160	\$0	\$0
Non-participating	\$270	\$140	0%	\$140	\$130	\$130 (\$270 - \$140)

For illustrative purposes only. Fees vary by procedure and location. Illustration assumes 100% coverage for P&D.

Getting a Crown						
	Dentist's charge	Sample Delta Dental fees	Co-payment	Delta Dental Pays	Balance billed amount	Amount you pay out of pocket
PPO Network	\$1,438	\$790	50%	\$395	\$0	\$395 (\$790 - \$395)
Premier Network	\$1,438	\$930	50%	\$465	\$0	\$465 (\$930 - \$465)
Non-participating	\$1,438	\$790	50%	\$395	\$648	\$1,043 (\$1,438 - \$395)

For illustrative purposes only. Fees vary by procedure and location.



Delta Dental of New Jersey, Inc.
Rate Proposal for: Borough of Glassboro Board of Education
For inclusion in the Allen Associates Dental Alliance

Current Plan, MAC OON

Delta Dental PPO Plus Premier			
Dentist Used	Delta Dental PPO	Delta Dental Premier	Non-Participating
Deductible	None	None	None
P&D	100%	100%	100%
Basic & Crowns	80%	80%	80%
Major	50%	50%	50%
Annual maximum	\$1,000	\$1,000	\$1,000
Orthodontics	50%	50%	50%
Lifetime maximum	\$1,000	\$1,000	\$1,000
Orthodontics Type	Child Only	Child Only	Child Only
Child Orthodontics to Age	19	19	19
Reimbursement level	PPO Fee Schedule	Premier Fee Schedule	Non-Par MAC
P&D services:	Fluoride Treatments (Frequency limitations apply);Sealants;Space Maintainers;Exams;Cleanings;Bitewing X-Rays;Full Mouth X-Rays		
Basic services:	Fillings;Simple Extractions;Root Canals (Endodontics);Periodontics;Oral Surgery		
Crowns:	Crowns & Gold Restorations		
Major services:	Bridgework;Full & Partial Dentures;Repair of Dentures		

With the Delta Dental PPO Plus Premier program, members utilizing Delta Dental PPO or Delta Dental Premier dentists will enjoy protection from balance billing in addition to access to Delta Dental's largest provider network. Claims for Delta Dental PPO dentists will be reimbursed using Delta Dental's deeper discounted PPO fees. Claims for Delta Dental Premier dentists will be reimbursed using Delta Dental's discounted Premier fees. With the broad coverage of the Premier network, Delta Dental PPO Plus Premier groups average in-network utilization ranging from 85-90%.

Claims for non-participating dentists will be reimbursed up to Delta Dental's maximum allowable charges.

Dependent children are covered to age 26.

Three cleanings and exams are covered per year.

The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provisions, including limitations and exclusions, are provided in the group contract.



Delta Dental of New Jersey, Inc.
Rate Proposal for: Borough of Glassboro Board of Education

Current Plan, MAC OON

Contract tier	Assumed enrollment	Fully Insured monthly rates
Employee only	62	\$41.21
Employee & spouse	40	\$100.07
Employee & 1 child	7	\$100.07
Employee & children	11	\$100.07
Family	88	\$108.43
Total enrollment	208	
Monthly Premium		\$17,901
Annual Premium		\$214,811

Underwriting policies and requirements

- Proposed rates are valid for 7/1/2025 - 6/30/2026.
- Delta Dental reserves the right to adjust rates if the actual enrollment varies by 10% or more from the assumed enrollment.
- The rates are contingent upon the employer contributing 65% of the premium for all eligible employees and 65% for dependents.
- The above rates include the following broker commission: 10% of the first \$5,000 of annual premium, 4% of the next \$95,000 of annual premium, 3% of annual premium over \$100,000.

Dental Proposed Rates

Group: Glassboro Board of Education

Plan: DeltaCare® USA Plan 14A

Contract type: Non - Retention

Full Contract term: 07/01/2025 to 06/30/2027

Initial contract term: 07/01/2025 to 06/30/2027



**Enrollee
Only**
\$16.78



**Enrollee
& Spouse**
\$40.82



**Enrollee
& Children**
\$40.82



**Enrollee
& Family**
\$44.23

The above rates include 6.00% broker commission.

The above rates are not valid unless accompanied by the provisions in the attached pages.

DeltaCare® USA availability

This DeltaCare® USA plan design is available only to those employees who reside within network service areas in DE, NJ, PA.



Assumptions and guidelines

Proposal Disclosure

The rates quoted in this proposal are based on the information provided to Delta Dental at the time the proposal was released. This proposal is not a contract. If the group wishes to sign a contract with Delta Dental, it will be required to complete and sign a Group Application. Delta Dental's acceptance of a completed Group Application will be based on verification of group enrollment specifications.

If during the Contract Term any new or increased tax, assessment or fee is imposed on the amounts payable to or by Delta Dental under this Contract or any immediately preceding contract between Delta Dental and Contractholder, the Premium amount will be increased by the amount of any such new or increased tax, assessment or fee by written notice to Contractholder, and the Contract shall thereby be modified on the date set forth in the notice.

Fully Insured Non-Retention Contract

Any profit or loss remaining at the end of the contract period will be absorbed by Delta Dental. The client assumes no liability in a loss situation.

Rate Guarantee

Rates are valid if purchased by the proposed effective date of 7/1/2025. Delta Dental recommends 90 days advance notice for implementation.

Contribution and Participation

Rates assume an employer contribution of 50% toward the employee cost and 50% toward the dependent cost of coverage for all eligible employees. Rates assume that there will be a minimum enrollment of 37 primary enrollees.

Eligibility

Eligible employees may enroll on the first day of the month following completion of the employer's required eligibility period. Eligible employees who decline dental coverage may elect to enroll at the next open enrollment. The same requirements also apply for dependent coverage. Primary enrollees electing dependent coverage must enroll all eligible dependents in the dental program. Eligibility for employees and dependents is subject to all state laws or regulatory requirements. Enrollees eligible for optional continuation of group benefits under the Consolidated Omnibus Reconciliation Act of 1986 (COBRA) may continue coverage as allowed by law.

Limitations and Exclusions

The proposed plan will be administered to match the current plan's benefits, limitations and exclusions as closely as possible.

Program Design Detail

A complete listing of covered services and patient co-payments is included in the attached table.

Delta Dental Plan Information

MF5

Customer service for DeltaCare USA enrollees will be provided by Delta Dental Insurance Company ("Delta Dental"), administrator for the DeltaCare USA program. Delta Dental will issue ID cards for DeltaCare USA."&" Delta Dental reserves the right to review and approve all printed material related to the DeltaCare USA program.

Minor Variations in Plan Design

There may be minor state specific differences in the limitations, exclusions and governing administrative policies of the DeltaCare USA plans offered. Such variations are the result of legislative requirements of each state's regulatory body.

Single Dental Carrier

It is assumed that Delta Dental is to be the only dental carrier and that all primary enrollees (and their dependent enrollees) will be covered under our plan(s).

* DeltaCare® USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare® USA administrator in all these states. These companies are financially responsible for their own products.

SCHEDULE A

Description of Benefits and Copayments *

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost

D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (<i>within the 6 month period</i>) .	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (<i>within the 6 month period</i>) .	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1354	Application of caries arresting medicament - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$60.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$60.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$60.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$70.00
D1526	Space maintainer - removable - bilateral, maxillary	\$70.00

D1527	Space maintainer - removable - bilateral, mandibular	\$70.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$12.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$12.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$12.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$12.00
D1557	Removal of fixed bilateral space maintainer - maxillary	\$12.00
D1558	Removal of fixed bilateral space maintainer - mandibular	\$12.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	\$60.00

D2000-D2999 III. RESTORATIVE

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

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

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	\$5.00
D2331	Resin-based composite - two surfaces, anterior	\$10.00
D2332	Resin-based composite - three surfaces, anterior	\$15.00
D2335	Resin-based composite - four or more surfaces (anterior)	\$50.00
D2390	Resin-based composite crown, anterior	\$60.00
D2391	Resin-based composite - one surface, posterior	\$55.00
D2392	Resin-based composite - two surfaces, posterior	\$65.00
D2393	Resin-based composite - three surfaces, posterior	\$75.00
D2394	Resin-based composite - four or more surfaces, posterior	\$85.00
D2510	Inlay - metallic - one surface	\$170.00
D2520	Inlay - metallic - two surfaces	\$180.00
D2530	Inlay - metallic - three or more surfaces	\$190.00
D2542	Onlay - metallic - two surfaces	\$185.00
D2543	Onlay - metallic - three surfaces	\$195.00
D2544	Onlay - metallic - four or more surfaces	\$215.00
D2610	Inlay - porcelain/ceramic - one surface	\$295.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$330.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$350.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$325.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$380.00
D2650	Inlay - resin-based composite - one surface	\$195.00
D2651	Inlay - resin-based composite - two surfaces	\$220.00
D2652	Inlay - resin-based composite - three or more surfaces	\$255.00
D2662	Onlay - resin-based composite - two surfaces	\$250.00
D2663	Onlay - resin-based composite - three surfaces	\$275.00
D2664	Onlay - resin-based composite - four or more surfaces	\$320.00
D2710	Crown - resin-based composite (indirect)	\$160.00
D2712	Crown - 3/4 resin-based composite (indirect)	\$160.00
D2720	Crown - resin with high noble metal	\$320.00
D2721	Crown - resin with predominantly base metal	\$220.00

D2722	Crown - resin with noble metal	\$260.00
D2740	Crown - porcelain/ceramic	\$380.00
D2750	Crown - porcelain fused to high noble metal	\$380.00
D2751	Crown - porcelain fused to predominantly base metal	\$280.00
D2752	Crown - porcelain fused to noble metal	\$320.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$380.00
D2780	Crown - 3/4 cast high noble metal	\$380.00
D2781	Crown - 3/4 cast predominantly base metal	\$280.00
D2782	Crown - 3/4 cast noble metal	\$320.00
D2783	Crown - 3/4 porcelain/ceramic	\$380.00
D2790	Crown - full cast high noble metal	\$380.00
D2791	Crown - full cast predominantly base metal	\$280.00
D2792	Crown - full cast noble metal	\$320.00
D2794	Crown - titanium and titanium alloys	\$380.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$15.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$15.00
D2920	Re-cement or re-bond crown	\$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	\$50.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	\$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	\$75.00
D2930	Prefabricated stainless steel crown - primary tooth	\$65.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$65.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$85.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$75.00
D2940	Placement of interim direct restoration	\$15.00
D2949	Restorative foundation for an indirect restoration	\$65.00
D2950	Core buildup, including any pins when required	\$65.00
D2951	Pin retention - per tooth, in addition to restoration	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$95.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$70.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$80.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$60.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	\$55.00
D2976	Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i>	No Cost
D2980	Crown repair necessitated by restorative material failure	\$25.00
D2981	Inlay repair necessitated by restorative material failure	\$25.00
D2982	Onlay repair necessitated by restorative material failure	\$25.00
D2983	Veneer repair necessitated by restorative material failure	\$25.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to 1 per 24 months</i>	\$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$35.00
D3221	Pulpal debridement, primary and permanent teeth	\$40.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$35.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$50.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$110.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$200.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration)	\$350.00
D3331	Treatment of root canal obstruction; non-surgical access	\$75.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$75.00
D3333	Internal root repair of perforation defects	\$75.00
D3346	Retreatment of previous root canal therapy - anterior	\$140.00
D3347	Retreatment of previous root canal therapy - premolar	\$230.00
D3348	Retreatment of previous root canal therapy - molar	\$380.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$75.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$50.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$50.00
D3410	Apicoectomy - anterior	\$130.00
D3421	Apicoectomy - premolar (first root)	\$140.00
D3425	Apicoectomy - molar (first root)	\$150.00
D3426	Apicoectomy (each additional root)	\$90.00
D3430	Retrograde filling - per root	\$70.00
D3450	Root amputation - per root	\$80.00
D3471	Surgical repair of root resorption - anterior	\$130.00
D3472	Surgical repair of root resorption - premolar	\$130.00
D3473	Surgical repair of root resorption - molar	\$130.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$130.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$130.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	\$130.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$70.00
D3921	Decoronation or submergence of an erupted tooth	\$8.00

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$145.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$85.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$90.00
D4245	Apically positioned flap	\$175.00
D4249	Clinical crown lengthening - hard tissue	\$140.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$345.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$275.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$225.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$75.00
D4270	Pedicle soft tissue graft procedure	\$225.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$80.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$225.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$225.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$55.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$45.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$55.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$40.00
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i>	\$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after

placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	\$335.00
D5120	Complete denture - mandibular	\$335.00
D5130	Immediate denture - maxillary	\$355.00
D5140	Immediate denture - mandibular	\$355.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$295.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$365.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$295.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$295.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$365.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$365.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery	\$415.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	\$415.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$295.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$295.00
D5410	Adjust complete denture - maxillary	\$12.00
D5411	Adjust complete denture - mandibular	\$12.00
D5421	Adjust partial denture - maxillary	\$12.00
D5422	Adjust partial denture - mandibular	\$12.00
D5511	Repair broken complete denture base, mandibular	\$45.00
D5512	Repair broken complete denture base, maxillary	\$45.00
D5520	Replace missing or broken teeth - complete denture - per tooth	\$25.00
D5611	Repair resin partial denture base, mandibular	\$50.00
D5612	Repair resin partial denture base, maxillary	\$50.00
D5621	Repair cast partial framework, mandibular	\$50.00
D5622	Repair cast partial framework, maxillary	\$50.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$50.00
D5640	Replace missing or broken teeth - partial denture - per tooth	\$40.00
D5650	Add tooth to existing partial denture - per tooth	\$40.00

D5660	Add clasp to existing partial denture - per tooth	\$50.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$180.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$180.00
D5710	Rebase complete maxillary denture	\$100.00
D5711	Rebase complete mandibular denture	\$100.00
D5720	Rebase maxillary partial denture	\$100.00
D5721	Rebase mandibular partial denture	\$100.00
D5725	Rebase hybrid prosthesis	\$100.00
D5730	Reline complete maxillary denture (chairside)	\$55.00
D5731	Reline complete mandibular denture (chairside)	\$55.00
D5740	Reline maxillary partial denture (chairside)	\$55.00
D5741	Reline mandibular partial denture (chairside)	\$55.00
D5750	Reline complete maxillary denture (laboratory)	\$90.00
D5751	Reline complete mandibular denture (laboratory)	\$90.00
D5760	Reline maxillary partial denture (laboratory)	\$90.00
D5761	Reline mandibular partial denture (laboratory)	\$90.00
D5765	Soft liner for complete or partial removable denture - indirect	\$90.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	\$110.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i> ...	\$110.00
D5850	Tissue conditioning, maxillary	\$25.00
D5851	Tissue conditioning, mandibular	\$25.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

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

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

D6210	Pontic - cast high noble metal	\$380.00
D6211	Pontic - cast predominantly base metal	\$280.00
D6212	Pontic - cast noble metal	\$320.00
D6240	Pontic - porcelain fused to high noble metal	\$380.00
D6241	Pontic - porcelain fused to predominantly base metal	\$280.00
D6242	Pontic - porcelain fused to noble metal	\$320.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$320.00
D6245	Pontic - porcelain/ceramic	\$380.00
D6250	Pontic - resin with high noble metal	\$320.00
D6251	Pontic - resin with predominantly base metal	\$220.00
D6252	Pontic - resin with noble metal	\$260.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$330.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$350.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$280.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$290.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$180.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$190.00

D6606	Retainer inlay - cast noble metal, two surfaces	\$210.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$220.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$325.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$360.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$285.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$295.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$185.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$195.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$205.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$225.00
D6720	Retainer crown - resin with high noble metal	\$320.00
D6721	Retainer crown - resin with predominantly base metal	\$220.00
D6722	Retainer crown - resin with noble metal	\$260.00
D6740	Retainer crown - porcelain/ceramic	\$380.00
D6750	Retainer crown - porcelain fused to high noble metal	\$380.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$280.00
D6752	Retainer crown - porcelain fused to noble metal	\$320.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$380.00
D6780	Retainer crown - 3/4 cast high noble metal	\$380.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$280.00
D6782	Retainer crown - 3/4 cast noble metal	\$320.00
D6783	Retainer crown - 3/4 porcelain/ceramic	\$380.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$380.00
D6790	Retainer crown - full cast high noble metal	\$380.00
D6791	Retainer crown - full cast predominantly base metal	\$280.00
D6792	Retainer crown - full cast noble metal	\$320.00
D6930	Re-cement or re-bond fixed partial denture	\$20.00
D6940	Stress breaker	\$45.00
D6980	Fixed partial denture repair necessitated by restorative material failure	\$60.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	\$5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$8.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$50.00
D7220	Removal of impacted tooth - soft tissue	\$60.00
D7230	Removal of impacted tooth - partially bony	\$80.00
D7240	Removal of impacted tooth - completely bony	\$110.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$130.00
D7250	Removal of residual tooth roots (cutting procedure)	\$45.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	\$130.00
D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i>	\$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$120.00
D7280	Exposure of an unerupted tooth	\$90.00

D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands - <i>does not include pathology laboratory procedures</i>	\$30.00
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	\$30.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$85.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$85.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$100.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$100.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	\$85.00
D7472	Removal of torus palatinus	\$85.00
D7473	Removal of torus mandibularis	\$85.00
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	\$75.00
D7971	Excision of pericoronal gingiva	\$75.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The Benefit for pre-treatment records and diagnostic services includes:

		\$200.00
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0322	Tomographic survey	
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	

D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	<i>The Benefit for post-treatment records includes:</i>	\$70.00
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	\$1,150.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$1,150.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,150.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,350.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$1,900.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,900.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$2,100.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i>	\$2,420.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	\$15.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$25.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$5.00
D9440	Office visit - after regularly scheduled hours	\$35.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost

D9932	Cleaning and inspection of removable complete denture, maxillary ..	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular ...	No Cost
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$100.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$100.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$100.00
D9951	Occlusal adjustment, limited	\$50.00
D9952	Occlusal adjustment, complete	\$100.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i> **	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i> **	\$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

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

* *Benefits may vary slightly based on state requirements and/or regulations.*

** *Not applicable in Texas or Washington*

*** *Provisions regarding copayments and in and out-of-network treatment vary in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont. See below.*

Alaska and North Dakota Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is \$500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may

contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Connecticut Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. Copayments apply for in-network treatment only. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Contract Fee for a covered service with a calendar year maximum of \$500.00. Enrollees are responsible for the other 50 percent plus the difference between the out-of-network Dentist's fee and the Contract Fee, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Idaho Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is \$500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the DeltaCare USA network.

Louisiana, Mississippi and North Carolina Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan is the fee actually charged by the out-of-network Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment. If the out-of-network Dentist's fee is greater than the Maximum Fee Allowance, the enrollee is responsible for the difference as well as the copayment. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Maine, New Hampshire and Vermont Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit paid by the Plan for out-of-network treatment is 80 percent of the fee charged by the Dentist or 80 percent of the Maximum Fee Allowance, whichever is lower, less the copayment. Enrollees are responsible for the copayments as well as the other 20 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Montana Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 75 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for the copayments as well as the other 25 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Oklahoma Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 70 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for Copayments as well as the other 30 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

South Dakota Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is \$500.00. Enrollees are responsible for the copayments, as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental Premier network.

SCHEDULE B

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in the *Description of Benefits and Copayments*.

(Frequency limitations on diagnostic and preventive procedures do not apply in Texas when services are needed more frequently due to medical necessity as determined by the Contract Dentist. In Maryland, the frequency for procedures D1110, D1120, D1206, D1208, D1354 and D4346 is 2 per calendar year.)

2. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).

New Hampshire Only:

General anesthesia and/or intravenous sedation/analgesia is limited to:

- a) treatment by an oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240 and D7241); or
- b) anesthesia administered by a licensed Dentist for dental procedures performed in a Dentist's office on a covered person who is:
 - i) a child under the age of 6 who is determined by a licensed Dentist, in conjunction with a licensed physician, to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or
 - ii) a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician, which places the person at serious risk.

Washington Only:

This limitation does not apply if general anesthesia services are medically necessary because the Enrollee is under age seven or is physically or developmentally disabled.

4. Benefits provided by a pediatric Dentist are limited to children through age 13 and upon prior authorization by the Plan, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

5. Your cost for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

Maryland Only:

Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

You are receiving ongoing orthodontic treatment at the time of termination, We will continue to provide orthodontic Benefits for:

- 60 days if the Enrollee is making monthly payments to the Contract Orthodontist, or
- until the later of 60 days or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

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

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

Pennsylvania Only:

A Preexisting Condition is a disease or physical condition caused by illness or injury for which medical advice or treatment has been received within 90 days immediately prior to becoming eligible with the DeltaCare USA program. Such condition shall be covered after the individual has been covered for more than 12 months under the group contract. Example: Teeth prepared for crowns, root canals in progress or orthodontic treatment.

If an individual begins comprehensive orthodontic treatment within 90 days immediately prior to becoming eligible under the DeltaCare USA program, a waiting period of 12 months of continuous coverage under the DeltaCare USA program applies before coverage is available.

Texas Only:

7. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with this program are limited as follows:

Upon request of a newly covered Enrollee, the Plan will provide Benefits for the completion of covered services begun prior to the time his or her coverage became effective. The Plan will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. Enrollees may request completion of treatment in progress by calling the Customer Service department at 800-422-4234 during normal business hours, or by sending a written request to the Plan.

Whenever possible, an Enrollee should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for the Plan to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by the Enrollee and/or coverage provided by all plans is not more than 100% of total Allowable Expenses (as defined in the Coordination of Benefits section of the Contract).

Should the Enrollee be unable to complete treatment with the Dentist who initiated the service, the Plan will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.

Exclusions of Benefits

1. Any procedure that is not specifically listed under the *Description of Benefits and Copayments*. (Exclusion does not apply in South Dakota.)
2. Any procedure that in the professional opinion of the Contract Dentist:
 - * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
 - * is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

Minnesota only:

This exclusion does not apply to 1) the treatment of covered dependent children with congenital defects or birth abnormalities which result in a functional defect as determined by their attending physician; 2) dental treatment for the management of cleft lip or cleft palate when such treatment is scheduled or initiated prior to the dependent child turning age 19; or 3) dental reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part.

South Carolina Only:

This exclusion does not apply to, teeth capping, prosthodontics, and orthodontics necessary for the treatment of congenital cleft lip or cleft palate.

4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

Minnesota only:

This exclusion does not include covered services provided by a provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with Craniomandibular Disorder and myofascial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

Washington Only:

This exclusion does not apply to dental services specifically covered under a TMJ Rider **

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered Benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage. (*Exclusion does not apply in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota or Vermont.*)
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision. (*Exclusion does not apply in Pennsylvania or Texas.*)
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind. (*Exclusion does not apply in New York.*)
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9944, D9945, D9946 (occlusal guards). (*Exclusion does not apply in New York.*)
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services. (*Exclusion does not apply in Maryland.*)
19. Maryland Only:

Specialist or orthodontic treatment resulting from a prohibited referral. A prohibited referral is when the Contract Dentist directs an Enrollee to seek specialist or orthodontic care from another dental facility where a) the Contract Dentist owns a beneficial interest in the practice; b) the Contract Dentist's immediate family owns a beneficial interest of 3 percent or greater in the practice; or c) the Contract Dentist, the Contract Dentist's immediate family or a combination of the Contract Dentist and his or her immediate family has a compensation arrangement with the practice.

** Washington statutes require that carriers offer a TMJ Rider which covers certain TMJ procedures. This rider is available to groups with employees located in Washington and is available for Washington enrollees only. For additional information on the TMJ Rider, contact your broker and/or sales representative.

Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont Only:

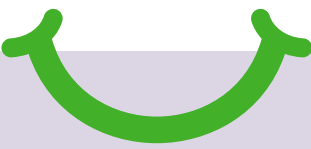
In accordance with state regulatory requirements, DeltaCare USA is offered as an open access plan in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont. Enrollees can obtain treatment from any licensed dentist or orthodontist. Unless it is specifically noted, all Limitations and Exclusions would apply to both "Contract" and "Non-Contracted" dentists and orthodontists.



Getting Started is as Easy as 1, 2, 3!



- 1 Complete your new group paperwork. This includes signing a fully insured group application, a PHI authorization form, and contract. For self-insured groups, we require a signed Business Associate Agreement.
- 2 Enroll your eligible employees and their dependents by providing either an Excel spreadsheet in an approved format, EDI file, or paper enrollment forms. After your group is set up, you can use our portal to manage your eligibility if you are not sending an EDI file.
- 3 Promote the program to members initially and at least annually to new members.
 - Delta Dental will provide all the materials you need.
 - You may also allow us to market the program directly to members.
 - You may approve communications to members beforehand.



That's all
there is to it!

Delta Dental of New Jersey, Inc.
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Parsippany, NJ 07054

[DeltaDentalNJ.com](https://www.DeltaDentalNJ.com)