



Our Medicare Advantage Supplemental Dental Program

Welcome.

Your dental program is administered by Delta Dental Plan of Arkansas, Inc. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 1-855-253-4706 (TTY Users call 711) Monday through Friday, 8 a.m. to 8 p.m. For specific benefit information, access Allwell from Arkansas Health & Wellness' website at allwell.arhealthwellness.com.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalAR.com/medicare-advantage and selecting the link for our Member Toolkit. The Member Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you.

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Allwell from Arkansas Health & Wellness

Allwell Medicare (HMO) Supplemental Dental Plan

Group Number: 5000-0005

Summary of Dental Plan Benefits For Allwell Medicare Premier (HMO) Client 5000-0005 Optional Supplemental Dental Plan

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage™ Network will result in your out of pocket costs being higher. Please note Delta Dental's Medicare Advantage Network only consists of dentists in the state of Arkansas.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the full cost of those services and no payment will be made by Delta Dental.

Control Plan – Delta Dental of Arkansas

Benefit Year – January 1 through December 31, 2021

Covered Services –

Covered Services –	Delta Dental Medicare Advantage Dentist Plan Pays	Nonparticipating (out-of-network) Dentist Plan Pays*
Diagnostic & Preventive		
Diagnostic and Preventive Services – exams, cleanings, and fluoride.	100%	0%
Radiographs – bitewing and other X-rays	100%	0%
Brush Biopsy – to detect oral cancer	100%	0%
Basic Services		
Emergency Palliative Treatment – to temporarily relieve pain	80%	0%
Minor Restorative Services – fillings and crown repair	80%	0%
Major Restorative Services – crowns and onlays	80%	0%
Endodontic Services – root canals	80%	0%
Non-Surgical Periodontic Services – to treat gum disease	80%	0%
Other Basic Services – miscellaneous services	80%	0%
Major Services		
Oral Surgery Services –extractions and dental surgery	50%	0%
Prosthetic Services – bridges and dentures	50%	0%
Relines and Repairs – to bridges, implants and dentures	50%	0%
Surgical Periodontic Services – to treat gum disease	50%	0%

Members with Diabetes, Heart Disease or Periodontal Disease may be eligible for 2 additional routine cleanings (prophylaxes) or periodontal maintenance procedures for a total of 4 per calendar year. Members should talk with his or her dentist about treatment. The additional benefits may not be combined by those with more than one of the above conditions.

Maximum Payment – \$1500 per person total per Calendar Year on all services except cleanings, exams, fluoride, brush biopsy and X-rays.

Deductible – \$50 per person total per Calendar Year on all services except cleanings, exams, fluoride, brush biopsy and X-rays.

Waiting Period – Not applicable.

Eligible People – All members enrolled in the Allwell Medicare Premier (HMO) Medicare Advantage plan who choose the Optional Supplemental Dental Plan.

For enrollment and dis-enrollment information, please refer to your plan's *Evidence of Coverage*.

You may end your optional supplemental dental benefits by giving us written notice that you would like to end your coverage.

I. Delta Dental Certificate

Delta Dental Plan of Arkansas, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Member. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and Allwell from Arkansas Health & Wellness, your Medicare Advantage Plan.

The Benefits provided under This Plan may change if federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the Medicare Advantage Dentist Fee Schedule which Delta Dental will base its payment for a Covered Service.

Appeal

The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Year

The calendar year.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract

between Delta Dental and Allwell from Arkansas Health & Wellness.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the permanent cementation date;
- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Coinsurance

The percentage of the charge, if any, that you must pay for Covered Services.

Copayment

A fixed amount of money that you must pay for Covered Services, if any

Covered Code List

The unique list of the ADA dental codes that are covered services under This Plan. These codes are subject to the terms of this Certificate.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Arkansas, Inc., which provides dental benefits. Delta Dental is an Arkansas medical services corporation. Delta Dental Plan of Arkansas, Inc. has been delegated by Allwell from Arkansas Health & Wellness

Medicare Advantage to provide dental benefits for This Plan

Dental Emergency

A Dental Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- ◆ **Delta Dental Medicare Advantage Dentist** - a Dentist located in Arkansas who has signed an agreement with Delta Dental for This Plan that is part of Delta Dental Plan of Arkansas' Medicare Advantage Network.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Network or is located in a state other than Arkansas. **Services received from Dentists who do NOT participate in Delta Dental's Medicare Advantage Network are not Covered Services.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the full cost of the services and no payment will be made by Delta Dental.

Grievance

An expression of dissatisfaction with any aspect of the operations, activities or behavior of Delta Dental, Arkansas Health & Wellness Medicare Advantage or a Dentist that has provided dental services under This Plan.

Inquiry

A verbal or written request for information that does not involve a grievance, coverage or appeals process, such as a routine question about a benefit.

Maximum Approved Fee

The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty,

under normal circumstances, based upon applicable Delta Dental Medicare Advantage Dentist schedules and internal procedures.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits.)

Medicare Advantage Dentist Fee Schedule

The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Dentist as determined by Delta Dental.

Member

A person with coverage under This Plan.

Nonparticipating Dentist Fee

The most Delta Dental will pay Nonparticipating Dentists for a Covered Service.

Post-Service Claims

Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

Pre-Service Organization Determination

A determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your Dentist.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Service Organization Determinations and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Delta Dental Medicare Advantage Dentist cannot charge you for the difference between this amount and the amount Delta Dental approves for the treatment.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental

Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for you pursuant to this Certificate.

III. Selecting a Dentist

To receive benefits under This Plan you must receive services from a Medicare Advantage Dentist. Services received from Dentists who do NOT participate in Delta Dental Plan of Arkansas' Medicare Advantage Network are not Covered Services.

Please note Delta Dental Plan of Arkansas' Medicare Advantage Network consists of Dentists in the state of Arkansas only.

To verify that a Dentist is a Delta Dental Medicare Advantage Dentist, you can use Delta Dental's online Dentist Directory at:

www.DeltaDentalAR.com/medicare-advantage

Or call us at:

1-855-253-4706 (TTY Users call 711).

If the Dentist you select is not a Delta Dental Medicare Advantage Dentist, services are not covered. You will be responsible for the full cost of the services and no payment will be made by Delta Dental.

The provider network may change at any time. You will receive notice when necessary.

IV. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental's Medicare Advantage dental plan. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9230, Farmington Hills, Michigan 48333, or calling the toll-free number at 1-855-253-4706 (TTY Users call 711).
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

- a. Your full name and address
- b. Your Allwell from Arkansas Health & Wellness Member ID number
- c. Your date of birth

Notice of Claim Forms

Your Dentist should submit your dental claims form using the most recent American Dental Association ("ADA") approved claim form. Medicare Advantage Participating Dentists will fill out and submit your dental claims for you.

Mail claims and completed information requests to:

**Delta Dental
P.O. Box 9298
Farmington Hills, Michigan 48333**

Pre-Service Organization Determination

Your Dentist can submit a request for a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan through the Dental Office Toolkit® (DOT). You can also request a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan by calling the Customer Service department toll-free at (855) 253-4706 or in writing at:

**Delta Dental
P.O. Box 9230
Farmington Hills, MI 48333**

For a standard coverage decision, Delta Dental will provide an answer within 14 calendar days after receiving your request. To file a fast coverage decision the standard deadlines must potentially cause serious harm to your health or hurt your ability to function. If Delta Dental approves the fast request, an answer will be provided within 72 hours. For both standard and fast requests, Delta Dental may take up to 14 additional calendar days under certain circumstances. If additional time is taken, Delta Dental will notify you in writing and explain the reasons for the extension.

If Delta Dental does not approve your standard or fast coverage request, you have the right to file an appeal. Please see the Appeal section for more information. Availability of dental benefits at the time your request is completed is dependent on several factors. These factors include, but are not limited to, medical necessity, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's

limitations and any other provisions, together with any additional information or changes to your dental treatment. To determine whether a service may be covered under This Plan, please review the benefits included in this document.

Written Notice of Claim and Time of Payment

All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim for payment is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 60 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it will decide your claim and send you notice of that decision. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Grievance and Appeals Procedure section). You should call Delta Dental's Customer Service department, toll-free, at 1-855-253-4706 (TTY Users call 711), or write them at P.O. Box 9230, Farmington Hills, Michigan, 48333, to request a form to designate the person you wish to appoint as your representative or you may use the CMS Appointment of Representative Form (Form CMS-1696). While in some circumstances your Dentist is treated as your authorized representative, generally Delta Dental only recognizes the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to Delta Dental's Customer Service department, at 1-855-253-4706 (TTY Users call 711) (toll-free). You may also write to Delta Dental's Customer Service department at P.O. Box 9230, Farmington Hills, Michigan, 48333. When writing to Delta Dental, please include your name, your Allwell from Arkansas Health & Wellness Member ID number, and your daytime telephone number.

V. How Payment is Made

If your Dentist is a Delta Dental Medicare Advantage Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to the Delta Dental Medicare Advantage Participating Dentist and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

If your Dentist is a Nonparticipating Dentist, services are not covered and Delta Dental will make no payment.

VI. Benefit Categories

Important

ONLY the dental services listed in your Summary of Dental Plan Benefits and Covered Code List are covered by This Plan. Covered Services are also subject to exclusions and limitations. You will want to review this section of this Certificate carefully.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits or Covered Code List. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.

3. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
9. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
12. Services or supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies.
13. Services or supplies received due to an act of war, declared or undeclared.
14. Services or supplies covered under a hospital, surgical/medical, (including Medicare Advantage), or prescription drug program.
15. Services or supplies that are not within the categories of Benefits selected by your Medicare Advantage Organization and that are not covered under the terms of this Certificate.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
19. Sealants.
20. Space Maintainers.
21. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.
26. Paste-type root canal fillings on permanent teeth.
27. Implant/abutment supported interim fixed denture for edentulous arch.
28. Soft occlusal guard appliances.
29. Implants.
30. Repair, relines, or adjustments of occlusal guards.
31. Chemical curettage.
32. Services associated with overdentures.
33. Metal bases on removable prostheses.
34. The replacement of teeth beyond the normal complement of teeth.
35. Personalization or characterization of any service or appliance.
36. Temporary crowns used for temporization during crown or bridge fabrication.
37. Posterior bridges in conjunction with partial dentures in the same arch.
38. Precision attachments and stress breakers.

39. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
40. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
41. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
42. Orthodontic Services.
43. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
44. Myofunctional therapy.
45. Mounted case analyses.
46. Any and all taxes applicable to the services.
47. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Delta Dental Medicare Advantage Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups.
15. Any substructure when done for inlays, onlays, and veneers.
16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
21. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
22. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.

24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
29. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
30. Tissue conditioning, when performed on the same day as the delivery of a denture or the relining or rebase of a denture.
31. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
32. . Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
33. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with Allwell from Arkansas Health & Wellness:

1. Up to four individual bitewing X-rays are payable per calendar year, unless a full mouth X-ray

which include bitewings has been paid in that same year.

2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, and scaling in the presence of inflammation are payable twice per calendar year. Members with Diabetes, Heart Disease or Periodontal Disease may be eligible for 2 additional routine cleanings (prophylaxes) or periodontal maintenance procedures for a total of 4 per calendar year. Members should talk with his or her dentist about treatment. The additional benefits may not be combined by those with more than one of the above conditions. Full mouth debridement is payable once in a lifetime.
4. Periodontal maintenance is payable twice per calendar year.
5. Oral examinations and evaluations (not included limited problem focused evaluations or patient screenings are only payable twice per calendar year, regardless of the Dentist's specialty.
6. Patient screening is payable once per calendar year.
7. Preventive fluoride treatments are payable once per calendar year up to age 19.
8. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
9. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
10. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
11. Inhalation of nitrous oxide is payable without limitation.
12. Therapeutic antibiotic drug injection and medicaments dispensed in the office are payable without limitation.

13. Localized delivery of antimicrobial agents via a controlled release is payable without limitation.
14. An occlusal guard is payable once in a five year period.
15. Assessments of salivary flow by measurement are payable once in any 36-month period.
16. An interim partial denture is payable only during the healing period for people age 17 and over.
17. Prosthodontic Services limitations:
 - a. Once complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. Fixed bridges and removable partial dentures are not payable for people under age 16.
 - d. A relines or the complete replacement of denture base material is payable once in any three-year period per appliance.
18. Frenectomy is payable without limitation.
19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to dis-enroll that was accepted by your plan during a valid Medicare election period. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

For example:

 - a. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - b. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
 - c. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
 - d. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - e. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
23. Maximum Payment: All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits..
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

25. Caries risk assessments are payable once in any 36-month period for Members age 3-18. In the event a caries risk assessment is performed on a Member age 2 or under, such risk assessment will be treated as a Disallow.
26. Processing Policies may otherwise limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Delta Dental Medicare Advantage Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with Allwell from Arkansas Health & Wellness:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue Conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.

10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same Dentist/dental office.
13. Processing Policies may limit Delta Dental's payment for services or supplies.

VIII. Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a Person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100 percent of the total allowable expense.

Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies;

Medicare supplement policies; or coverage under other federal governmental plans that do not permit coordination.

Each contract for coverage under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan, for purposes of this section, means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that the total benefits paid by all Plans do not exceed the Submitted Amount. In no event will This Plan's payments exceed the Maximum Approved Fee.

Order of Benefits Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. This Plan will pay primary over any Medicaid or Retiree Plan that you may have.
2. This Plan will pay secondary to any employer sponsored, automobile, group, or individual Plan you may have, except for those listed in (1) above.
3. If This Plan is the Primary Plan, it will pay its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
4. Except as provided in the following paragraph, a Plan that does not contain a COB provision is always primary unless otherwise required by law.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any

other parts of the Plan provided by the contract holder, shall be secondary regardless of whether or not it contains a COB provision.

5. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Submitted Amount. In determining the amount to be paid, This Plan will calculate the benefits it would have paid in the absence of other health care coverage (Maximum Approved Fee) and apply that the remaining amount that you owe to the Dentist following the Primary Plan's payment. The amount paid by This Plan will not exceed the Maximum Approved Fee.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-855-253-4706 (TTY Users call 711), and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at PO Box 9230, Farmington Hills, Michigan, 48333. You may also follow the Grievance and Appeals Procedure below

IX. Grievance and Appeals Procedures

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within **60 days** of the date that you received that Adverse Benefit Determination. Allwell from Arkansas Health & Wellness may give you more time if you have a good reason for missing the deadline. Requests for a review must be submitted to:

Allwell from Arkansas Health & Wellness

Attn: Medicare Appeals & Grievances
7700 Forsyth Blvd.
Saint Louis, MO 63105

Fax: 1-844-273-2671

Phone: 1-855-565-9518

TTY: 711

Please include your name and address, the Member ID, the explanation of benefits, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. Indicate in your letter that you are requesting a formal appeal (Standard Appeal) of your claim. You also have the right to review any documents related to your appeal. If you would like a record of your request and proof that Allwell from Arkansas Health & Wellness received it, mail your request certified mail, return receipt requested.

If you want someone else to act for you, you can name a relative, friend, attorney, dentist or someone else to act as your representative. You can do this by following the Authorized Representative section above. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax the statement to Allwell from Arkansas Health & Wellness.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

The notice of any adverse determination regarding your appeal will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain

a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review.

Adverse appeals will be automatically submitted to the CMS's contracted independent review entity within 60 calendar days from the date Allwell from Arkansas Health & Wellness received the member's first level appeal. The Appeals Staff will concurrently notify the member that the appeal is being forwarded to CMS's independent review entity.

If you have a complaint or dispute, other than an Adverse Benefit Determination, such as dissatisfaction with the manner in which Allwell from Arkansas Health & Wellness, Delta Dental or a dentist has provided dental services, you can contact write to Allwell from Arkansas Health & Wellness at the address listed above in this section within 60 days of the event. Allwell from Arkansas Health & Wellness will respond in writing to all Grievances within 30 days of receipt.

X. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ◆ When Allwell from Arkansas Health & Wellness advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which Allwell from Arkansas Health & Wellness has failed to pay Delta Dental.
- ◆ For fraud or misrepresentation in the submission of any claim.
- ◆ For any other reason stated in the contract between Delta Dental and Allwell from Arkansas Health & Wellness.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by Allwell from Arkansas Health & Wellness. A person whose eligibility is terminated may not continue coverage under this Certificate.

XI. General Conditions

Subrogation and Right of Reimbursement

If you are involved in an automobile accident or require Covered Services that may entitle you to

recover from a third party and Delta Dental advances payment to prevent any financial hardship, you have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You are required to provide Delta Dental with any information about any other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid.

You must:

1. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
2. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
3. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
4. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

You agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

You are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If you lose eligibility while receiving dental treatment, only Covered Services received while you are covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Certificate or Contract

No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Certificate will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Governing Law

This Certificate and the underlying group contract will be governed by and interpreted under Centers for Medicare and Medicaid (CMS).

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts, it may recover that payment from you. You authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you. Delta Dental will

provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

1-800-524-0147 (TTY Users call 711)

You can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on company holidays.

Allwell is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Allwell depends on contract renewal.

This information is not a complete description of benefits. Call 1-855-253-4706 (TTY Users call 711) for more information.

This section provides a list of dental procedures covered by your plan. If a procedure is not on this list, it is not a standard covered benefit under your plan. Standard benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in Section VII of your Delta Dental Certificate. The May Require Review or Documentation column identifies whether a procedure may require diagnostic information or may be routinely reviewed.

*Please note, procedures in the following code ranges may require routine review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations: D0220-D0250, D0999 Diagnostic; D1999 Preventive; D2710-D2794, D2910-D2934, D2950-D2999 Restorative; D3000-D3999 Endodontics; D4000-D4999 Periodontics; D5110-D5671, D5875-D5999 Prosthodontics (Removable); D6000-D6199 Implant Services; D6200-D6999 Prosthodontics (Fixed); D7111-7999 Oral and Maxillofacial Surgery; D9120, D9310, D9410, D9420, D9930 and D9999 Adjunctive Services

**Please note, Members with Diabetes, Heart Disease or Periodontal Disease may be eligible for 2 additional routine cleanings (prophylaxes) or periodontal maintenance procedures for a total of 4 per calendar year. Members should talk with his or her dentist about treatment. The additional benefits may not be combined by those with more than one of the above conditions.

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Benefit Limitations	If yes, this procedure may require review or documentation	Documentation Required
D0100-D0999 Diagnostic						
D0120	periodic oral evaluation - established patient	100%	0%	Twice per calendar year		
D0140	limited oral evaluation - problem focused	100%	100%	As needed for diagnosis of emergency condition		
D0150	comprehensive oral evaluation - new or established patient	100%	0%	Once per 36 months		
D0160	detailed and extensive oral evaluation - problem focused, by report	100%	0%	Once per 36 months		
D0180	comprehensive periodontal evaluation - new or established patient	100%	0%	Once per calendar year		
D0190	screening of a patient	100%	0%	Once per calendar year		
D0210	intra-oral - complete series	100%	0%	Once per 5 year period		
D0220	intraoral - periapical first image	100%	0%	Covered service		
D0230	intraoral - periapical each additional image	100%	0%	Covered service		
D0240	intraoral - occlusal image	100%	0%	Covered service		
D0250	extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	100%	0%	Covered service		
D0270	bitewing - single image	100%	0%	Once per calendar year - (up to four films)		
D0272	bitewings - two images	100%	0%	Once per calendar year - (up to four per calendar year)		
D0273	bitewings - three images	100%	0%	Once per calendar year - (four films per calendar year)		
D0274	bitewings - four images	100%	0%	Once per calendar year - (four films per calendar year)		
D0277	vertical bitewings - 7 to 8 images	100%	0%	Once per calendar year - four films per calendar year		
D0330	panoramic image	100%	0%	Once per 5 year period		
D0419	assessment of salivary flow, by measurement	80%	0%	Once per 3 year period		
D0460	pulp vitality tests	80%	0%	Payable per visit not per tooth for the diagnosis of emergency conditions		
D0999*	unspecified diagnostic procedure, by report	100%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D1000-D1999 Preventive						
D1110**	prophylaxis - adult	100%	0%	Twice per calendar year; two additional cleanings per calendar year for members with specific health conditions.		
D2000-D2999 Restorative						
D2140	amalgam - one surface, primary or permanent	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2150	amalgam - two surfaces, primary or permanent	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2160	amalgam - three surfaces, primary or permanent	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2161	amalgam - four or more surfaces, primary or permanent	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Benefit Limitations	If yes, this procedure may require review or documentation	Documentation Required
D2330	resin-based composite - one surface, anterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2331	resin-based composite - two surfaces, anterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2332	resin-based composite - three surfaces, anterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2390	resin-based composite crown, anterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2391	resin-based composite - one surface, posterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2392	resin-based composite - two surfaces, posterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2393	resin-based composite - three surfaces, posterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2394	resin-based composite - four or more surfaces, posterior	80%	0%	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface		
D2410	gold foil - one surface	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140)		
D2420	gold foil - two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2150)		
D2430	gold foil - three surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2160)		
D2510	inlay - metallic - one surface	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140)		
D2520	inlay - metallic - two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2150)		
D2530	inlay - metallic - three or more surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2160 or D2161)		
D2542	onlay - metallic - two surfaces	80%	0%	Once per 5 year period		
D2543	surfaces	80%	0%	Once per 5 year period		
D2544	onlay - metallic - four or more surfaces	80%	0%	Once per 5 year period		
D2610	inlay - porcelain/ceramic - one surface	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140)		
D2620	inlay - porcelain/ceramic - two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2150)		
D2630	inlay - porcelain/ceramic - three surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2160)		

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Benefit Limitations	If yes, this procedure may require review or documentation	Documentation Required
D2642	onlay - porcelain/ceramic - two surfaces	80%	0%	Once per 5 year period;		
D2643	onlay - porcelain/ceramic - three surfaces	80%	0%	Once per 5 year period;		
D2644	onlay - porcelain/ceramic - four or more surfaces	80%	0%	Once per 5 year period;		
D2650	inlay - resin-based composite - one surface	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140)		
D2651	inlay - resin-based composite - two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2150)		
D2652	inlay - resin-based composite - three or more surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2160 or D2161)		
D2662	onlay - resin-based composite - two surfaces	80%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay (D2542)		
D2663	onlay - resin-based composite - three surfaces	80%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay (D2543)		
D2664	onlay - resin-based composite - four or more surfaces	80%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay (D2544)		
D2710*	crown - resin-based composite (indirect)	80%	0%	Once per 5 year period;	Yes	
D2712*	crown - 3/4 resin-based composite (indirect)	80%	0%	Once per 5 year period;	Yes	
D2720*	crown - resin with high noble metal	80%	0%	Once per 5 year period;	Yes	
D2721*	crown - resin with predominantly base metal	80%	0%	Once per 5 year period;	Yes	
D2722*	crown - resin with noble metal	80%	0%	Once per 5 year period;	Yes	
D2740*	crown - porcelain/ceramic	80%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2790)	Yes	
D2750*	crown - porcelain fused to high noble metal	80%	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2790)	Yes	
D2751*	crown - porcelain fused to predominantly base metal	80%	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2791)	Yes	
D2752*	crown - porcelain fused to noble metal	80%	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2792)	Yes	
D2753*	crown - porcelain fused to titanium and titanium alloys	80%/optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2794)	Yes	
D2780*	metal	80%	0%	Once per 5 year period	Yes	
D2781*	crown - 3/4 cast predominantly base metal	80%	0%	Once per 5 year period	Yes	
D2782*	crown - 3/4 cast noble metal	80%	0%	Once per 5 year period	Yes	
D2783*	crown - 3/4 porcelain/ceramic	80%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown.	Yes	
D2790*	crown - full cast high noble metal	80%	0%	Once per 5 year period	Yes	
D2791*	crown - full cast predominantly base metal	80%	0%	Once per 5 year period	Yes	
D2792*	crown - full cast noble metal	80%	0%	Once per 5 year period	Yes	
D2794*	crown - titanium and titanium alloys	80%	0%	Once per 5 year period	Yes	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	80%	0%	Covered service		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	80%	0%	Covered service		
D2920	re-cement or re-bond crown	80%	0%	Covered service		

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Benefit Limitations	If yes, this procedure may require review or documentation	Documentation Required
D2921	reattachment of tooth fragment, incisal edge or cusp	80%	0%	Covered service		
D2929	prefabricated porcelain/ceramic crown - primary tooth	80%	0%	Covered service		
D2930	prefabricated stainless steel crown - primary tooth	80%	0%	Covered service		
D2931	prefabricated stainless steel crown - permanent tooth	80%	0%	Covered service		
D2932	prefabricated resin crown	80%	0%	Covered service		
D2933	prefabricated stainless steel crown with resin window	80%	0%	Covered service		
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	80%	0%	Covered service		
D2940	protective restoration	80%	0%	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)		
D2941	interim therapeutic restoration - primary dentition	80%	0%	Once per primary tooth		
D2950*	core buildup, including any pins when required	80%	0%	Once per 5 year period	Yes	
D2951*	pin retention - per tooth, in addition to restoration	80%	0%	Once per tooth per lifetime	Yes	
D2952*	post and core in addition to crown, indirectly fabricated	80%	0%	Once per 5 year period	Yes	
D2954*	prefabricated post and core in addition to crown	80%	0%	Once per 5 year period	Yes	
D2955	post removal	80%	0%	Covered service		
D2971	additional procedures to construct new crown under existing partial denture framework	80%	0%	Covered service		
D2980	crown repair necessitated by restorative material failure	80%	0%	Covered service		
D2981	inlay repair necessitated by restorative material failure	80%	0%	Covered service		
D2982	onlay repair necessitated by restorative material failure	80%	0%	Covered service		
D2983	veneer repair necessitated by restorative material failure	80%	0%	Covered service		
D2999*	unspecified restorative procedure, by report	80%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D3000-D3999 Endodontics						
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinoocemental junction and application of medicament	80%	0%	Covered service	Yes	
D3221*	pulpal debridement, primary or permanent teeth	80%	80%	Covered service	Yes	
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	80%	0%	Once per tooth per lifetime; additional benefit will require review	Yes	
D3230*	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	80%	0%	Covered service	Yes	
D3240*	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	80%	0%	Covered service	Yes	
D3310*	endodontic therapy, anterior tooth (excluding final restoration)	80%	0%	Covered service	Yes	
D3320*	endodontic therapy, premolar tooth (excluding final restoration)	80%	0%	Covered service	Yes	
D3330*	endodontic therapy, molar tooth (excluding final restoration)	80%	0%	Covered service	Yes	
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	80%	0%	Covered service	Yes	
D3333*	internal root repair of perforation defects	80%	0%	Covered service	Yes	
D3346*	retreatment of previous root canal therapy - anterior	80%	0%	Covered service	Yes	
D3347*	retreatment of previous root canal therapy - premolar	80%	0%	Covered service	Yes	
D3348*	retreatment of previous root canal therapy - molar	80%	0%	Covered service	Yes	
D3351*	apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	80%	0%	Covered service	Yes	

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D3352*	apexification/recalcification interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	80%	0%	Covered service	Yes	
D3353*	apexification/recalcification-final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	80%	0%	Covered service	Yes	
D3410*	apicoectomy - anterior	80%	0%	Covered service	Yes	
D3421*	apicoectomy - premolar (first root)	80%	0%	Covered service	Yes	
D3425*	apicoectomy - molar (first root)	80%	0%	Covered service	Yes	
D3426*	apicoectomy (each additional root)	80%	0%	Covered service	Yes	
D3427*	periradicular surgery without apicoectomy	80%	0%	Covered service	Yes	
D3430*	retrograde filling - per root	80%	0%	Covered service	Yes	
D3450*	root amputation - per root	80%	0%	Covered service	Yes	
D3920*	hemisection (including any root removal), not including root canal therapy	80%	0%	Covered service	Yes	
D3999	unspecified endodontic procedure, by report	80%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D4000-D4999 Periodontics						
D4210*	four or more contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4211*	one to three contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4240*	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4241*	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4245*	apically positioned flap	50%	0%	Covered service	Yes	
D4249*	clinical crown lengthening - hard tissue	50%	0%	Once per tooth per 24 month period	Yes	
D4260*	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4261*	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	0%	Once per 36 month period	Yes	
D4263*	bone replacement graft - retained natural tooth - first site in quadrant	50%	0%	Once per 36 month period	Yes	
D4264*	bone replacement graft - retained natural tooth - each additional site in quadrant	50%	0%	Once per 36 month period	Yes	
D4265*	soft and osseous tissue regeneration	50%	0%	Once per 36 month period	Yes	
D4266*	guided tissue regeneration - resorbable barrier, per site	50%	0%	Once per 36 month period	Yes	
D4267*	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	50%	0%	Once per 36 month period	Yes	
D4268*	surgical revision procedure, per tooth	50%	0%	Once per 36 month period	Yes	
D4270*	pedicle soft tissue graft procedure	50%	0%	Once per 36 month period	Yes	
D4273*	free soft tissue graft procedure (including donor site surgery)	50%	0%	Once per 36 month period	Yes	
D4274*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	50%	0%	Covered service	Yes	
D4275*	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	50%	0%	Once per 36 month period	Yes	

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D4276*	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	50%	0%	Once per 36 month period	Yes	
D4277*	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	50%	0%	Once per 36 month period	Yes	
D4278*	free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft	50%	0%	Once per 36 month period	Yes	
D4283*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in the same graft site	50%	0%	Once per 36 month period	Yes	
D4285*	non-autogenous connective tissue graft (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	50%	0%	Once per 36 month period	Yes	
D4341*	periodontal scaling and root planing - four or more teeth per quadrant	80%	0%	No more than 2 quadrants of scaling and root planing on the same date of service	Yes	
D4342*	periodontal scaling and root planing - one to three teeth per quadrant	80%	0%	No more than 2 quadrants of scaling and root planing on the same date of service	Yes	
D4346*	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	80%	0%	Including in the cleaning frequency of twice per calendar year	Yes	
D4355*	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	80%	0%	Once per lifetime	Yes	
D4381	localized delivery of antimicrobial agents	80%	0%			
D4910**	periodontal maintenance	80%	0%	Twice per calendar year; two additional cleanings per calendar year for members with specific health conditions.	Yes	
D4999	unspecified periodontal procedure, by report	80%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D5000-D5899 Prosthodontics (Removable)						
D5110*	complete denture - maxillary	50%	0%	Once per five-year period	Yes	
D5120*	complete denture - mandibular	50%	0%	Once per five-year period	Yes	
D5130*	immediate denture - maxillary	50%	0%	Once per five-year period	Yes	
D5140*	immediate denture - mandibular	50%	0%	Once per five-year period	Yes	
D5211*	maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5212*	mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5213*	maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5214*	mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5221*	immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5222*	immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5223*	immediate maxillary partial denture - cast metal framework with resin denture base (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	

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D5224*	immediate mandibular denture partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5225*	maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5226*	mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	0%	Once per five-year period	Yes	
D5282*	removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	50%	0%	Once per five-year period	Yes	
D5283*	removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	50%	0%	Once per five-year period	Yes	
D5284*	removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	50%	0%	Once per five-year period	Yes	
D5286*	removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	50%	0%	Once per five-year period	Yes	
D5410	adjust complete denture - maxillary	50%	0%	Covered service		
D5411	adjust complete denture - mandibular	50%	0%	Covered service		
D5421	adjust partial denture - maxillary	50%	0%	Covered service		
D5422	adjust partial denture - mandibular	50%	0%	Covered service		
D5511	repair broken complete denture base, mandibular	50%	0%	Covered service		
D5512	repair broken complete denture base, maxillary	50%	0%	Covered service		
D5520	replace missing or broken teeth - complete denture (each tooth)	50%	0%	Covered service		
D5611	repair resin partial denture base, mandibular	50%	0%	Covered service		
D5612	repair resin partial denture base, maxillary	50%	0%	Covered service		
D5621	repair cast partial framework, mandibular	50%	0%	Covered service		
D5622	repair cast partial framework, maxillary	50%	0%	Covered service		
D5630	repair or replace broken retentive clasping materials - per tooth	50%	0%	Covered service		
D5640	replace broken teeth - per tooth	50%	0%	Covered service		
D5650	add tooth to existing partial denture	50%	0%	Covered service		
D5660	add clasp to existing partial denture - per tooth	50%	0%	Covered service		
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	50%	0%	Covered service		
D5671	cast metal framework (mandibular)	50%	0%	Covered service		
D5710	denture	50%	0%	Once per 36 month period		
D5711	rebase complete mandibular denture	50%	0%	Once per 36 month period		
D5720	rebase maxillary partial denture	50%	0%	Once per 36 month period		
D5721	denture	50%	0%	Once per 36 month period		
D5730	reline complete maxillary denture (chairside)	50%	0%	Once per 36 month period		
D5731	reline complete mandibular denture (chairside)	50%	0%	Once per 36 month period		
D5740	reline maxillary partial denture (chairside)	50%	0%	Once per 36 month period		
D5741	reline mandibular partial denture (chairside)	50%	0%	Once per 36 month period		
D5750	reline complete maxillary denture (laboratory)	50%	0%	Once per 36 month period		
D5751	reline complete mandibular denture (laboratory)	50%	0%	Once per 36 month period		
D5760	reline maxillary partial denture (laboratory)	50%	0%	Once per 36 month period		
D5761	reline mandibular partial denture (laboratory)	50%	0%	Once per 36 month period		
D5820	interim partial denture (maxillary)	50%	0%	Payable for the replacement of permanent anterior teeth during the healing period		
D5821	interim partial denture (mandibular)	50%	0%	Payable for the replacement of permanent anterior teeth during the healing period		

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D5850	tissue conditioning, maxillary	50%	0%	Twice per 36 month period		
D5851	tissue conditioning, mandibular	50%	0%	Twice per 36 month period		
D5863	overdenture - complete maxillary	Optional	0%	Plan will pay only the applicable amount that it would have paid for a conventional full denture (D5110)		
D5864	overdenture - partial maxillary	Optional	0%	amount that it would have paid for a conventional partial denture (D5211)		
D5865	overdenture - complete mandibular	Optional	0%	Plan will pay only the applicable amount that it would have paid for a conventional full denture (D5120)		
D5866	overdenture - partial mandibular	Optional	0%	amount that it would have paid for a conventional partial denture (D5212)		
D5875	modification of removable prosthesis following implant surgery	50%	0%	Subject to review	Yes	
D5899	unspecified removable prosthodontic procedure, by report	50%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D5931	obturator prosthesis, surgical	50%	0%	Subject to review	Yes	
D5999	unspecified maxillofacial prosthesis, by report	50%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D6000-D6199 Implant Services						
D6080*	implant maintenance procedures - when prostheses are removed and reinserted, including cleansing of prostheses and abutments	50%	0%	Once per 12 month period	Yes	
D6090*	repair implant supported prosthesis, by report	50%	0%	Covered service	Yes	
D6092*	reinsert implant/abutment supported crown	50%	0%	Covered service	Yes	
D6093*	reinsert implant/abutment supported fixed partial denture	50%	0%	Covered service	Yes	
D6095*	repair implant abutment, by report	50%	0%	Covered service	Yes	
D6096*	remove broken implant retaining screw	50%	0%	1 per 5 year period	Yes	
D6200-D6999 Prosthodontics (Fixed)						
D6205*	pontic - indirect resin based composite	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	
D6210*	pontic - cast high noble metal	50%	0%	1 per 5 year period	Yes	
D6211*	metal	50%	0%	1 per 5 year period	Yes	
D6212*	pontic - cast noble metal	50%	0%	1 per 5 year period	Yes	
D6214*	pontic - titanium and titanium alloys	50%	0%	1 per 5 year period	Yes	
D6240*	pontic - porcelain fused to high noble metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6210)	Yes	
D6241*	pontic - porcelain fused to predominantly base metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6211)	Yes	
D6242*	pontic - porcelain fused to noble metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6212)	Yes	
D6243*	pontic - porcelain fused to titanium and titanium alloys	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic.	Yes	
D6245*	pontic - porcelain/ceramic	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	
D6250*	pontic - resin with high noble metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6214)	Yes	
D6251*	pontic - resin with predominantly base metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic.	Yes	
D6252*	pontic - resin with noble metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6211)	Yes	
D6545*	retainer - cast metal for resin bonded fixed prosthesis	50%	0%	Once per 5 year period per consultant review	Yes	
D6548*	retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	

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D6549*	resin retainer - for resin bonded fixed prosthesis	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	
D6600*	retainer inlay - porcelain/ceramic, two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for a full metal inlay (D6602)	Yes	
D6601*	retainer inlay - porcelain/ceramic, three or more surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for a full metal inlay (D6603)	Yes	
D6602*	retainer inlay - cast high noble metal, two surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6603*	retainer inlay - cast high noble metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6604*	retainer inlay - cast predominantly base metal, two surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6605*	retainer inlay - cast predominantly base metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6606*	retainer inlay - cast noble metal, two surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6607*	retainer inlay - cast noble metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6608*	retainer onlay - porcelain/ceramic, two surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for a full metal onlay (D6610)	Yes	
D6609*	retainer onlay - porcelain/ceramic, three or more surfaces	Optional	0%	Plan will pay only the applicable amount that it would have paid for a full metal onlay (D6611)	Yes	
D6610*	retainer onlay - metal, two surfaces	50%	0%	consultant review	Yes	
D6611*	retainer onlay - cast high noble metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6612*	retainer onlay - cast predominantly base metal, two surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6613*	retainer onlay - cast predominantly base metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6614*	retainer onlay - cast noble metal, two surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6615*	retainer onlay - cast noble metal, three or more surfaces	50%	0%	Once per 5 year period per consultant review	Yes	
D6624*	retainer inlay - titanium	50%	0%	Once per 5 year period per consultant review	Yes	
D6634*	retainer onlay - titanium	50%	0%	Once per 5 year period per consultant review	Yes	
D6710*	retainer crown - indirect resin based composite	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	
D6720*	retainer crown - resin with high noble metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6790)	Yes	
D6721*	retainer crown - resin with predominantly base metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6791)	Yes	
D6722*	retainer crown - resin with noble metal	50%/Optional	0%	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6792)	Yes	
D6740*	retainer crown - porcelain/ceramic	Optional	0%	Benefits may be considered for a conventional fixed prosthesis	Yes	
D6750*	retainer crown - porcelain fused to high noble metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6790)	Yes	
D6751*	retainer crown - porcelain fused to predominantly base metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6791)	Yes	
D6752*	retainer crown - porcelain fused to noble metal	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6792)	Yes	
D6753*	retainer crown - porcelain fused to titanium and titanium alloys	50%/Optional	0%	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6794)	Yes	

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D6780*	retainer crown - 3/4 cast high noble metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6781*	retainer crown - 3/4 cast predominantly base metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6782*	retainer crown - 3/4 cast noble metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6783*	retainer crown - 3/4 porcelain/ceramic	Optional	0%	Plan will pay only the applicable amount that it would have paid for a full metal retainer crown		
D6784*	retainer crown - 3/4 titanium and titanium alloys	50%	0%	Once per 5 year period per consultant review	Yes	
D6790*	retainer crown - full cast high noble metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6791*	retainer crown - full cast predominantly base metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6792*	retainer crown - full cast noble metal	50%	0%	Once per 5 year period per consultant review	Yes	
D6794*	retainer crown - titanium and titanium alloys	50%	0%	Once per 5 year period per consultant review	Yes	
D6930*	re-cement or re-bond fixed partial denture	50%	0%	Covered service	Yes	
D6980*	fixed partial denture repair, necessitated by restorative material failure	50%	0%	Covered service	Yes	
D6999*	unspecified fixed prosthodontic procedure, by report	50%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D7000-D7999 Oral and Maxillofacial Surgery						
D7111*	extraction, coronal remnants - primary tooth	80%	0%	Once per tooth per lifetime	Yes	
D7140*	extraction, erupted tooth or exposed tooth (elevation and or forceps removal)	80%	0%	Once per tooth per lifetime	Yes	
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	50%	0%	Once per tooth per lifetime	Yes	
D7220*	removal of impacted tooth - soft tissue	50%	0%	Once per tooth per lifetime	Yes	
D7230*	removal of impacted tooth - partially bony	50%	0%	Once per tooth per lifetime	Yes	
D7240*	removal of impacted tooth - completely bony	50%	0%	Once per tooth per lifetime	Yes	
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	50%	0%	Once per tooth per lifetime	Yes	
D7250*	removal of residual tooth roots (cutting procedure)	50%	0%	Once per tooth per lifetime	Yes	
D7251*	coronectomy - intentional partial tooth removal	50%	0%	Once per tooth per lifetime	Yes	
D7270*	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	0%	Covered service	Yes	
D7280*	exposure of an unerupted tooth	50%	0%	Once per tooth per lifetime	Yes	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	50%	0%	Once per tooth per lifetime		
D7283	facilitate eruption of impacted tooth	50%	0%	Covered service		
D7286	biopsy of oral tissue - soft	50%	0%	Subject to services it is performed in conjunction with. Predetermination is strongly recommended.		
D7288*	brush biopsy - transepithelial sample collection	100%	0%	Covered service		
D7290	surgical repositioning of teeth	50%	0%	Covered service		
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	50%	0%	Covered service		
D7310	with extractions - four or more teeth or tooth spaces, per quadrant	50%	0%	Covered service		
D7311	with extractions - one to three teeth or tooth spaces, per quadrant	50%	0%	Covered service		
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	0%	Covered service		
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50%	0%	Covered service		
D7510	incision and drainage of abscess - intraoral soft tissue	50%	0%	Covered service		
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	0%	Covered service		

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D7960	frenulectomy	50%	0%			
D7963	frenuloplasty	50%	0%			
D7910	suture of recent small wounds up to 5 cm	50%	0%	Covered service		
D7970	excision of hyperplastic tissue - per arch	50%	0%	Covered service		
D7971	excision of pericoronal gingiva	50%	0%	Covered service		
D7999	unspecified oral surgery procedure, by report	50%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment
D9000-D9999 Adjunctive General Services						
D9110	palliative (emergency) treatment of dental pain - minor procedure	80%	80%	As needed for diagnosis of emergency condition		
D9120	fixed partial denture sectioning	80%	0%	Covered service		
D9222	deep sedation/general anesthesia - first 15 minutes	80%	0%	Paid in conjunction with qualifying services		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	80%	0%	Paid in conjunction with qualifying services		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	80%	0%			
D9239	intravenous moderate (conscious) sedation/analgesia - first 15 minutes	80%	0%	Paid in conjunction with qualifying services		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	80%	0%	Paid in conjunction with qualifying services		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	80%	0%	Covered service		
D9410*	call	80%	0%	Requires consultant review	Yes	
D9420*	hospital or ambulatory surgical center call	80%	0%	Requires consultant review	Yes	
D9440	office visit - after regularly scheduled hours	100%	0%	As needed for diagnosis of emergency condition		
D9610	therapeutic parenteral drug, single	80%	0%			
D9612	therapeutic parenteral drug, two or more	80%	0%			
D9630	drugs or medicament dispensed in the office for home use	80%	0%			
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	80%	0%	Covered service		
D9944	occlusal guard - hard appliance, full arch	80%	0%	Once per 60 months		
D9945	occlusal guard - soft appliance, full arch	80%	0%	Once per 60 months		
D9946	occlusal guard - hard appliance, partial arch	80%	0%	Once per 60 months		
D9951	occlusal adjustment - limited	80%	0%	Payable three times in a five-year period		
D9952	occlusal adjustment - complete	80%	0%	Payable once in a five-year period		
D9999*	unspecified adjunctive procedure, by report	80%	0%	Benefit determined by consultant review	Yes	Report clarifying the service and verifying the need for treatment

This plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-855-253-4706 (TTY users call 711).

If you believe that this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at 7700 Forsyth Blvd., Saint Louis, MO 63105; by phone at 1-877-935-8024 (TTY users call 711) or fax to 1-844-273-2671. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل على الهاتف رقم 1-855-253-4706 (رقم الطابعة الهاتفية: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-253-4706 (TTY : 711)。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-253-4706 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-253-4706 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। कॉल करें 1-855-253-4706 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-253-4706 (TTY : 711) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-253-4706 (TTY: 711) 번으로 전화해 주십시오.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-253-4706 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-253-4706 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-253-4706 (TTY: 711).

ધ્યાન આપો: જો તમે [ગુજરાતી] બોલતાં હો તો વિના મૂલ્ય ભાષાકીય સહાયતા સેવાઓ તમારે માટે ઉપલબ્ધ છે. કૌલ કરો 1-855-253-4706 (TTY: 711).

LALE: Ñe kwōj kōnono Kajin Majō ĩ, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejje ĩok wōñāñ. Kaalok 1-855-253-4706 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-253-4706 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-253-4706 (TTY: 711).

ໂປດ ຊາບ: ຖ້າວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາສາ, ໃດຍບໍ່ ເສັຽ ຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທສ 1-855-253-4706 (TTY: 711).