Inter Valley Health Plan
Medicare plans for health. Not for profit.

2022 Dental Benefits & Copayment Schedule

Basic Dental Plan & Optional Enhanced Dental Plan

Service To Seniors (HMO)
Desert Preferred Choice (HMO)

Welcome to Delta Dental (DHMO)

Inter Valley Health Plan partners with Delta Dental to provide our members with routine dental coverage which is a Non-Medicare covered benefit.

The Basic Dental Plan gives you comprehensive coverage with no waiting periods or deductibles. You can upgrade to the Optional Enhanced Dental Plan which offers lower copayments for your dental procedures.

This book lists the Basic Dental Plan & the Optional Enhanced Dental Plan copayments. It is designed to help you understand what to expect when using your Delta Dental Dental Plan.

DELTA DENTAL

Delta Dental is a registered mark of Delta Dental Plans Association.

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INTRODUCTION

We are pleased to welcome you to the dental plan for INTER VALLEY HEALTH PLAN Service To Seniors (HMO) and Desert Preferred Choice (HMO). This plan is administered by Delta Dental of California ("Delta Dental"). Our goal is to provide you with high quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

This DHMO plan is available in the following counties: Los Angeles, Orange, Riverside and San Bernardino.

Using This Schedule of Copay Booklet

This Dental Benefit Addendum ("Plan"), which includes Schedule A, Schedule of Copayments and Schedule B, Services, Limitations and Exclusions, discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the Plan works and how to obtain dental care. Please read this booklet completely and carefully. Please read the Definitions section, which will explain any words that have special or technical meanings in this Plan.

The benefit explanations contained in this Plan booklet are subject to all provisions of the Contract on file with INTER VALLEY HEALTH PLAN ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This Plan booklet is a summary of your dental plan, and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered Benefits, services or payments.*

Contact Delta Dental

For more information please visit www1.deltadentalins.com/ivhp or call Delta Dental's Customer Service Center at (855) 370-3801 (TTY 711). A Customer Service Representative can answer questions you may have about obtaining dental care,

help you locate a Delta Dental Participating Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental's automated information line at (855) 370-3801 (TTY 711) during regular business hours to obtain information about Member's eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental of California
560 Mission Street
Suite 1300
San Francisco, CA 94105

How to use this Plan - Choice of Participating Provider

To receive Benefits under this Plan, you must select a Participating Provider from the directory of Participating Providers. If you fail to select a Participating Provider or the Participating Provider selected by you becomes unavailable, we will request you select another Participating Provider or we will assign you to a Participating Provider. You may change your assigned Participating Provider by directing a request to the Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711). In order to ensure that your Participating Provider is notified and our eligibility lists are correct, changes in Participating Providers must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Plan and the address and telephone number of your Participating Provider. After the effective date in your membership packet, you may obtain dental services under the Plan. To make an appointment simply call your Participating Provider's facility and identify yourself as a Member through INTER VALLEY HEALTH PLAN. Inquiries regarding availability of appointments and accessibility of Participating Providers should be directed to the Customer Service department at (855) 370-3801 (TTY users 711).

EACH MEMBER MUST GO TO HIS OR HER ASSIGNED PARTICIPATING PROVIDER TO OBTAIN COVERED SERVICES, EXCEPT EMERGENCY SERVICES OR SERVICES PROVIDED BY A SPECIALIST, WHICH MUST BE PREAUTHORIZED IN WRITING BY DELTA DENTAL. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.

If your assigned Participating Provider's agreement with Delta Dental terminates, that Participating Provider will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Existing Members:

You may have the right to have completion of care with your terminated Participating Provider for certain specified dental conditions. Please call Customer Service at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request

to continue under the care of your terminated Participating Provider. We are not required to continue your care with that Participating Provider if you are not eligible for coverage under the Plan or if we cannot reach agreement with your terminated Participating Provider on the terms regarding your care.

New Members:

You may have the right to the qualified benefit of completion of care with a Non Participating Provider for certain specified dental conditions. Please call the Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your current Non Participating Provider. Delta Dental is not required to continue your care with that dentist if you are not eligible under the Plan or if they cannot reach agreement with your dentist on the terms regarding your care.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711).

Benefits, Limitations and Exclusions

The Basic Dental DHMO Plan and the Optional Enhanced Dental DHMO Plan provide the Benefits described in Schedule A, Description of Benefits and Copayments subject to the limitations and exclusions described in Schedule B. The services are performed as deemed appropriate by your attending Participating Provider. A Participating Provider may provide services either personally or through associated dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedule A, Description of Benefits and Copayments directly to the Participating Provider or Specialist who provides treatment. Charges for broken appointments (unless notice is received by the dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the Description of Benefits and Copayments.

Emergency Services

If Emergency Services are needed, you should contact your Participating Provider whenever possible. If you are a new Member needing Emergency Services, but do not have an assigned Participating Provider yet, contact Delta Dental's Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for help in locating a Participating Provider. Benefits for Emergency Services by a Non Participating Provider are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1. have made a reasonable attempt to contact the Participating Provider and the Participating Provider is unavailable or you cannot be seen within 24 hours of making contact; or

2. have made a reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or

3. reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Participating Provider to receive Emergency Services.

Benefits for Emergency Services not provided by the Participating Provider are limited to a maximum of $100.00 per emergency less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a dentist other than your Participating Provider.

Specialist Services

Specialist Services must be referred by the assigned Participating Provider and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by Delta Dental less any applicable Copayments.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Participating Provider. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) or write to Delta Dental.

Second opinions will be provided at another Participating Provider's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by a Non Participating Provider if an appropriately qualified Participating Provider is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file an Appeal with INTER VALLEY HEALTH PLAN. Please refer to the section of this booklet titled "Grievance and Appeals Process" below for an explanation of how to file an Appeal.

Claims for Reimbursement

Claims for Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P. O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Participating Provider is compensated by Delta Dental through monthly capitation (an amount based on the number of Members assigned to the Participating Provider), and by Members through required

Cost Sharing for treatment received. A Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Member. In no event does Delta Dental pay a Participating Provider or a Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Participating Provider, you will not be liable to that Participating Provider for any sums owed by us. The Participating Provider's contract with Delta Dental contains a provision prohibiting the Participating Provider from charging a Member for any sums owed by Delta Dental. Except for the provisions in Emergency Services, if you have not received Preauthorization for treatment from a Non Participating Provider or Specialist, and we fail to pay that dentist you may be liable to that dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number listed in this booklet.

Processing Policies

The dental care guidelines for the Plan explain to Participating Providers what services are covered under the dental Contract. Participating Providers will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Participating Provider that fall under the scope of Benefits of the dental Plan are provided subject to any Copayments. If a Participating Provider believes that a Member should obtain treatment from a Specialist, the Participating Provider contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Specialist. A Member may contact Delta Dental's Customer Service department at (855) 370-3801 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for information regarding the dental care guidelines for the Plan.

Coordination of Benefits

This Plan provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits Plan if the other policy or Plan covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Plan by Specialists or Non Participating Providers are coordinated with such other group dental insurance policy or any group dental benefits Plan. The determination of which policy or Plan is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

- the amount that it would have paid in the absence of any other dental benefit coverage, or
- the enrollee's total out-of-pocket cost payable under the primary dental benefit plan.

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

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by our telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with INTER VALLEY HEALTH PLAN.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and INTER VALLEY HEALTH PLAN does not accept the change. All Benefits terminate for any Member as of the date that this Plan is terminated, such person ceases to be eligible under the terms of this Plan, or such person's enrollment is cancelled under the terms of this Plan. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Plan was in effect.

Cancellation of Enrollment

To be eligible for Benefits under this Plan, you must be enrolled under one of the various Medicare Advantage health plans or products offered by INTER VALLEY HEALTH PLAN. If you lose your eligibility or you terminate your enrollment under your INTER VALLEY HEALTH PLAN you are not eligible to receive Benefits under this Plan. See your INTER VALLEY HEALTH PLAN Evidence of Coverage Booklet for enrollment terms and conditions.

Inter Valley Health Plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called "**Optional Supplemental Benefits**." If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

You may elect to enroll in the Optional Enhanced Dental plan for $14.80 per month. The Enrollment period for the Optional Enhanced Dental plan ends March 31, 2022 for current members. For New Members, you have the option of enrolling up to 60 days after your effective date. Once you've enrolled and we receive your application, your Optional Enhanced Dental plan benefits will become effective on the first of the following month if your enrollment is received before the 15th of the month.

To enroll in the Optional Enhanced Dental plan, call Inter Valley Health Plan Member Care Team at 800-251-8191 (TTY 711) and ask for a "Dental Enrollment Form." Return the completed form to Inter Valley Health Plan.

You can pay your premium monthly or annually. The grace period for your optional supplemental benefits is 60 days. Therefore, if you do not pay your premiums, your optional supplemental benefits will terminate after 60 days.

If you are disenrolled due to nonpayment of premiums, you will not be able to re-enroll in an optional supplemental benefits package until the next year.

If you decide you no longer want to be enrolled in an optional supplemental benefits package, send us a statement of your request. Please make sure to clarify that you do not want to disenroll from the Medicare Advantage plan, just the optional supplemental benefits portion. Your statement should include your name, Member ID number and signature. Any premium overpayments will be refunded to you. All cancellation requests received by the 15th of the month will take effect on the first of the following month. Once you have disenrolled from these benefits, you will not be able to re-enroll until next year.

OPTIONAL SUPPLEMENTAL BENEFITS	WHAT YOU MUST PAY WHEN YOU GET THESE SERVICES
Optional Enhanced Dental Plan	
Premium:	$14.80 monthly premium
Dental Services:	See chart below for a list of the covered routine dental and specialist procedures and copayments.

Optional Enhanced Dental Plan

Extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member.

If you want these optional supplemental benefits, you must sign up for them and you will have to pay an additional premium for them.

SCHEDULE A

Description of Benefits and Copayments

Basic Dental Plan

DHMO Mandatory – CAC05

& Optional Enhanced Dental Plan

DHMO Buy-Up – CAC06

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. Members should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes,

descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D0100-D0999 I. DIAGNOSTIC			
D0120	Periodic oral evaluation - established patient	$0	$0
D0140	Limited oral evaluation - problem focused	$0	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0	$0
D0150	Comprehensive oral evaluation - new or established patient	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	$0
D0171	Re-evaluation - post-operative office visit	$0	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0	$0
D0210	Intraoral - complete series of radiographic images	$0	$0
D0220	Intraoral - periapical first radiographic image	$0	$0
D0230	Intraoral - periapical each additional radiographic image	$0	$0
D0240	Intraoral - occlusal radiographic image	$0	$0
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	$0	$0
D0270	Bitewing - single radiographic image	$0	$0
D0272	Bitewings - two radiographic images	$0	$0
D0273	Bitewings three radiographic images	$0	$0
D0274	Bitewings - four radiographic images	$0	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0	$0
D0330	Panoramic radiographic image	$0	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0	$5
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$5	$5
D0415	Collection of microorganisms for culture and sensitivity	$10	$10
D0425	Caries susceptibility tests	$7	$5

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$7	$5
D0460	Pulp vitality tests	$0	$0
D0470	Diagnostic casts	$5	$5
D0601	Caries risk assessment and documentation, with a finding of low risk	$10	$8
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$10	$8
D0603	Caries risk assessment and documentation, with a finding of high risk	$10	$8
D0999	Office visit unspecified diagnostic procedure, by report	$4	$4
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	$5	$0
D1120	Prophylaxis - child	$5	$0
D1206	Topical application of fluoride varnish	$12	$5
D1208	Topical application of fluoride - excluding varnish	$5	$0
D1310	Nutritional counseling for control of dental disease	$0	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0	$0
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant - per tooth	$36	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$52	$15
D1353	Sealant repair - per tooth	$5	$0
D1354	Application of caries arresting medicament application - per tooth	$15	$15
D1510	Space maintainer - fixed - unilateral - per quadrant	$40	$20
D1516	Space maintainer - fixed - bilateral, mixillary	Not Covered	$30
D1517	Space maintainer - fixed - bilateral, mandibular	Not Covered	$30
D1520	Space maintainer - removable - unilateral - per quadrant	$30	$15
D1526	Space maintainer - removable - bilateral, maxillary	Not Covered	$20
D1527	Space maintainer - removable - bilateral, mandibular	Not Covered	$20
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	Not Covered	$0
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	Not Covered	$0

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	Not Covered	$0
D1556	Removal of fixed unilateral space maintainer - per quadrant	Not Covered	$0
D1557	Removal of fixed bilateral space maintainer - maxillary	Not Covered	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	Not Covered	$0
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	$40	$20
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.			
D2140	Amalgam - one surface, primary or permanent	$60	$3
D2150	Amalgam - two surfaces, primary or permanent	$74	$4
D2160	Amalgam - three surfaces, primary or permanent	$87	$6
D2161	Amalgam - four or more surfaces, primary or permanent	$101	$7
D2330	Resin-based composite - one surface, anterior	$76	$5
D2331	Resin-based composite - two surfaces, anterior	$89	$8
D2332	Resin-based composite - three surfaces, anterior	$103	$11
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$125	$14
D2390	Resin-based composite crown, anterior	$179	$45
D2391	Resin-based composite - one surface, posterior	$102	$50
D2392	Resin-based composite - two surfaces, posterior	$126	$65
D2393	Resin-based composite - three surfaces, posterior	$150	$85
D2394	Resin-based composite - four or more surfaces, posterior	$172	$105
D2510	Inlay - metallic - one surface	$353	$160
D2520	Inlay - metallic - two surfaces	$414	$160
D2530	Inlay - metallic - three or more surfaces	$468	$160
D2542	Onlay - metallic - two surfaces	$532	$160
D2543	Onlay - metallic - three surfaces	$545	$160
D2544	Onlay - metallic - four or more surfaces	$549	$160
D2610	Inlay - porcelain/ceramic - one surface	$408	$310
D2620	Inlay - porcelain/ceramic - two surfaces	$399	$330
D2630	Inlay - porcelain/ceramic - three or more surfaces	$417	$330

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D2642	Onlay - porcelain/ceramic - two surfaces	$541	$330
D2643	Onlay - porcelain/ceramic - three surfaces	$584	$330
D2644	Onlay - porcelain/ceramic - four or more surfaces	$620	$330
D2650	Inlay - resin-based composite - one surface	$334	$230
D2651	Inlay - resin-based composite - two surfaces	$436	$250
D2652	Inlay - resin-based composite - three or more surfaces	$474	$250
D2662	Onlay - resin-based composite - two surfaces	$280	$250
D2663	Onlay - resin-based composite - three surfaces	$384	$250
D2664	Onlay - resin-based composite - four or more surfaces	$426	$250
D2710	Crown - resin-based composite (indirect)	$304	$90
D2712	Crown - 3/4 resin-based composite (indirect)	$520	$90
D2720	Crown - resin with high noble metal	$503	$260
D2721	Crown - resin with predominantly base metal	$700	$110
D2722	Crown - resin with noble metal	$552	$235
D2740	Crown - porcelain/ceramic	$500	$330
D2750	Crown - porcelain fused to high noble metal	$454	$330
D2751	Crown - porcelain fused to predominantly base metal	$414	$180
D2752	Crown - porcelain fused to noble metal	$525	$305
D2753	Crown - porcelain fused to titanium and titanium alloys	Not Covered	$305
D2780	Crown - 3/4 cast high noble metal	$596	$310
D2781	Crown - 3/4 cast predominantly base metal	$523	$160
D2782	Crown - 3/4 cast noble metal	$520	$285
D2783	Crown - 3/4 porcelain/ceramic	$664	$210
D2790	Crown - full cast high noble metal	$584	$310
D2791	Crown - full cast predominantly base metal	$494	$160
D2792	Crown - full cast noble metal	$556	$285
D2794	Crown - titanium and titanium alloys	$612	$310
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	$200	$200
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$63	$10
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$62	$10
D2920	Re-cement or re-bond crown	$61	$10
D2921	Reattachment of tooth fragment, incisal edge or cusp	$113	$14
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$204	$40
D2930	Prefabricated stainless steel crown - primary tooth	$153	$40

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D2931	Prefabricated stainless steel crown - permanent tooth	$167	$40
D2932	Prefabricated resin crown	$177	$40
D2933	Prefabricated stainless steel crown with resin window	$229	$60
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$270	$50
D2940	Protective restoration	$63	$0
D2941	Interim therapeutic restoration - primary dentition	$74	$0
D2949	Restorative foundation for an indirect restoration	$72	$0
D2950	Core buildup, including any pins when required	$108	$25
D2951	Pin retention - per tooth, in addition to restoration	$47	$20
D2952	Post and core in addition to crown, indirectly fabricated	$149	$60
D2953	Each additional indirectly fabricated post - same tooth	$106	$0
D2954	Prefabricated post and core in addition to crown	$130	$55
D2955	Post removal	$121	$55
D2957	Each additional prefabricated post - same tooth	$97	$0
D2960	Labial veneer (resin laminate) - chairside	$303	$220
D2961	Labial veneer (resin laminate) - laboratory	$532	$260
D2962	Labial veneer (porcelain laminate) - laboratory	$673	$320
D2971	Additional procedures to construct new crown under existing partial denture framework	$86	$25
D2975	Coping	$238	$160
D2990	Resin infiltration of incipient smooth surface lesions	$75	$0
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$43	$10
D3120	Pulp cap - indirect (excluding final restoration)	$48	$4
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$110	$15
D3221	Pulpal debridement, primary and permanent teeth	$113	$15
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$154	$15
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$117	$45
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$136	$55
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$343	$60

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	$389	$90
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	$493	$160
D3331	Treatment of root canal obstruction; non-surgical access	$170	$35
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$178	$50
D3333	Internal root repair of perforation defects	$193	$35
D3346	Retreatment of previous root canal therapy - anterior	$439	$110
D3347	Retreatment of previous root canal therapy - premolar	$487	$190
D3348	Retreatment of previous root canal therapy - molar	$584	$300
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$181	$15
D3352	Apexification/recalcification - interim medication replacement (apical closure/ calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$147	$15
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$352	$15
D3355	Pulpal regeneration - initial visit	$231	$231
D3356	Pulpal regeneration - interim medication replacement	$231	$15
D3357	Pulpal regeneration - completion of treatment	$224	$15
D3410	Apicoectomy - anterior	$405	$60
D3421	Apicoectomy - premolar (first root)	$443	$60
D3425	Apicoectomy - molar (first root)	$495	$85
D3426	Apicoectomy (each additional root)	$136	$50
D3427	Periradicular surgery without apicoectomy	$260	$60
D3430	Retrograde filling - per root	$143	$40
D3450	Root amputation - per root	$327	$100
D3920	Hemisection (including any root removal), not including root canal therapy	$225	$115
D3921	Decoronation or submergence of an erupted tooth	$96	$5
D3950	Canal preparation and fitting of preformed dowel or post	$103	$55
D4000-D4999 V. PERIODONTICS			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$234	$110

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$146	$40
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$140	$40
D4230	Anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant	$1,178	$200
D4231	Anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant	$300	$150
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$357	$250
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$338	$200
D4245	Apically positioned flap	$283	$200
D4249	Clinical crown lengthening - hard tissue	$330	$250
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$618	$380
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$461	$310
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$299	$215
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$244	$120
D4266	Guided tissue regeneration - resorbable barrier, per site	$318	$230
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$292	$225
D4268	Surgical revision procedure, per tooth	$450	$450
D4270	Pedicle soft tissue graft procedure	$489	$445
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$450	$300
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$588	$445
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$416	$100

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	$240	$200
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	$240	$200
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$105	$40
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$78	$25
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$88	$40
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$78	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$50	$50
D4910	Periodontal maintenance	$66	$40
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$64	$64
D4921	Gingival irrigation - per quadrant	$35	$35
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.			
D5110	Complete denture - maxillary	$690	$220
D5120	Complete denture - mandibular	$684	$220
D5130	Immediate denture - maxillary	$713	$230
D5140	Immediate denture - mandibular	$715	$230
D5211	Maxillary partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	$622	$150
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$662	$150
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$721	$240
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$713	$240

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$639	$280
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$691	$280
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$834	$280
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$899	$280
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$562	$440
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$662	$440
D5227	Immediate maxillary partial denture - flexible base (including any claps, rests, and teeth)	$639	$280
D5228	Immediate mandibular partial denture - flexible base (including any claps, rests, and teeth)	$639	$280
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not Covered	$120
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not Covered	$120
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$440
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$440
D5410	Adjust complete denture - maxillary	$42	$0
D5411	Adjust complete denture - mandibular	$42	$0
D5421	Adjust partial denture - maxillary	$44	$0
D5422	Adjust partial denture - mandibular	$44	$0
D5511	Repair broken complete denture base, mandibular	Not Covered	$30
D5512	Repair broken complete denture base, maxillary	Not Covered	$30
D5520	Replace missing or broken teeth - complete denture (each tooth)	$74	$20
D5611	Repair resin partial denture base, mandibular	Not Covered	$30
D5612	Repair resin partial denture base, maxillary	Not Covered	$30

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D5621	Repair cast partial framework, mandibular	Not Covered	$50
D5622	Repair cast partial framework, maxillary	Not Covered	$50
D5630	Repair or replace broken retentive/clasping materials - per tooth	$125	$40
D5640	Replace broken teeth - per tooth	$79	$20
D5650	Add tooth to existing partial denture	$111	$20
D5660	Add clasp to existing partial denture - per tooth	$126	$30
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$421	$190
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$396	$190
D5710	Rebase complete maxillary denture	$288	$110
D5711	Rebase complete mandibular denture	$357	$110
D5720	Rebase maxillary partial denture	$279	$110
D5721	Rebase mandibular partial denture	$264	$110
D5725	Rebase hybrid prosthesis	$279	$110
D5730	Reline complete maxillary denture (chairside)	$146	$55
D5731	Reline complete mandibular denture (chairside)	$141	$55
D5740	Reline maxillary partial denture (chairside)	$135	$55
D5741	Reline mandibular partial denture (chairside)	$130	$55
D5750	Reline complete maxillary denture (laboratory)	$239	$80
D5751	Reline complete mandibular denture (laboratory)	$241	$80
D5760	Reline maxillary partial denture (laboratory)	$226	$80
D5761	Reline mandibular partial denture (laboratory)	$229	$80
D5765	Soft liner for complete or partial removable denture - indirect	$226	$80
D5810	Interim complete denture (maxillary)	$500	$90
D5811	Interim complete denture (mandibular)	$454	$90
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$248	$90
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$252	$90
D5850	Tissue conditioning, maxillary	$93	$25
D5851	Tissue conditioning, mandibular	$94	$25
D5863	Overdenture - complete maxillary	$1,294	$230
D5864	Overdenture - partial maxillary	$1,294	$230
D5865	Overdenture - complete mandibular	$909	$230

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D5866	Overdenture - partial mandibular	$1,113	$230
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered			
D6000-D6199 VIII. IMPLANT SERVICES			
- The following are limited to no more than two (2) each per calendar year: Implants, Implant supported prosthetics and Implant abutments.			
- Replacement of crowns, bridges and implant supported dentures requires the existing restoration to be 5+ years old.			
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*			
D6010	Surgical placement of implant body: endosteal implant	$1,500	$1,500
D6011	Surgical access to an implant body (second stage implant surgery)	$208	$200
D6051	Interim abutment	$200	$200
D6052	Semi-precision attachment abutment	$444	$200
D6056	Prefabricated abutment - includes modification and placement	$450	$450
D6057	Custom fabricated abutment - includes placement	$450	$450
D6058	Abutment supported porcelain/ceramic crown	$1,000	$1,000
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$1,150	$1,150
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$1,000	$1,000
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$1,125	$1,125
D6062	Abutment supported cast metal crown (high noble metal)	$1,150	$1,150
D6063	Abutment supported cast metal crown (predominantly base metal)	$1,000	$1,000
D6064	Abutment supported cast metal crown (noble metal)	$1,125	$1,125
D6065	Implant supported porcelain/ceramic crown	$1,000	$1,000
D6066	Implant supported crown - porcelain fused to high noble alloys	$1,150	$1,150
D6067	Implant supported crown - high noble alloys	$1,150	$1,150
D6068	Abutment supported retainer for porcelain/ceramic FPD	$1,000	$1,000
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$1,150	$1,150
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$1,000	$1,000

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$1,125	$1,125
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$1,150	$1,150
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$1,000	$1,000
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$1,125	$1,125
D6075	Implant supported retainer for ceramic FPD	$1,000	$1,000
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$1,150	$1,150
D6077	Implant supported retainer for metal FPD - high noble alloys	$1,150	$1,150
D6081	Scaling and debridement in the presence of inflammation or mucositis of a Single implant, including cleaning of the implant surfaces, without flap entry and closure	$97	$40
D6082	Implant supported crown - porcelain fused to predominantly base alloys	Not Covered	$1,000
D6083	Implant supported crown - porcelain fused to noble alloys	Not Covered	$1,150
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	Not Covered	$1,150
D6085	Provisional implant crown	$256	$200
D6086	Implant supported crown - predominantly base alloys	Not Covered	$1,150
D6087	Implant supported crown - noble alloys	Not Covered	$1,150
D6088	Implant supported crown - titanium and titanium alloys	Not Covered	$1,150
D6092	Re-cement or re-bond implant/abutment supported crown	$77	$30
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$95	$40
D6094	Abutment supported crown - titanium and titanium alloys	$841	$650
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	Not Covered	$1,150
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	Not Covered	$1,150
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	Not Covered	$1,150
D6104	Bone graft at time of implant placement	$343	$215
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$2,300	$2,300

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$2,300	$2,300
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$2,300	$2,300
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$2,300	$2,300
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	Not Covered	$1,150
D6121	Implant supported retainer for metal FPD - predominantly base alloys	Not Covered	$1,150
D6122	Implant supported retainer for metal FPD - noble alloys	Not Covered	$1,150
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	Not Covered	$1,150
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$776	$650
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	Not Covered	$1,150
D6198	Remove interim implant component	$0	$0
D6200-D6999 IX. PROSTHODONTICS, Fixed (each retainer and each pontic constitutes a unit in a fixed partial denture bridge)			
- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.			
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*			
D6205	Pontic - indirect resin based composite	$471	$110
D6210	Pontic - cast high noble metal	$531	$310
D6211	Pontic - cast predominantly base metal	$436	$160
D6212	Pontic - cast noble metal	$503	$285
D6214	Pontic - titanium and titanium alloys	$529	$310
D6240	Pontic - porcelain fused to high noble metal	$446	$330
D6241	Pontic - porcelain fused to predominantly base metal	$397	$180
D6242	Pontic - porcelain fused to noble metal	$517	$305
D6243	Pontic - porcelain fused to titanium alloys	Not Covered	$305
D6245	Pontic - porcelain/ceramic	$492	$180
D6250	Pontic - resin with high noble metal	$521	$260

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D6251	Pontic - resin with predominantly base metal	$492	$110
D6252	Pontic - resin with noble metal	$449	$235
D6253	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression	$200	$200
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$339	$140
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$442	$140
D6549	Retainer - for resin bonded fixed prosthesis	$315	$140
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$460	$330
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$639	$330
D6602	Retainer inlay - cast high noble metal, two surfaces	$469	$310
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$416	$310
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$353	$160
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$359	$160
D6606	Retainer inlay - cast noble metal, two surfaces	$650	$285
D6607	Retainer inlay - cast noble metal, three or more surfaces	$650	$285
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$520	$330
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$596	$330
D6610	Retainer onlay - cast high noble metal, two surfaces	$481	$310
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$572	$310
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$230	$160
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$540	$160
D6614	Retainer onlay - cast noble metal, two surfaces	$412	$285
D6615	Retainer onlay - cast noble metal, three or more surfaces	$454	$285
D6624	Retainer inlay - titanium	$350	$310
D6634	Retainer onlay - titanium	$350	$310
D6710	Retainer crown - indirect resin based composite	$378	$110
D6720	Retainer crown - resin with high noble metal	$415	$285
D6721	Retainer crown - resin with predominantly base metal	$439	$110
D6722	Retainer crown - resin with noble metal	$592	$235
D6740	Retainer crown - porcelain/ceramic	$504	$180
D6750	Retainer crown - porcelain fused to high noble metal	$447	$330

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D6751	Retainer crown - porcelain fused to predominantly base metal	$406	$180
D6752	Retainer crown - porcelain fused to noble metal	$533	$305
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	$305
D6780	Retainer crown - 3/4 cast high noble metal	$591	$310
D6781	Retainer crown - 3/4 cast predominantly base metal	$421	$160
D6782	Retainer crown - 3/4 cast noble metal	$511	$285
D6783	Retainer crown - 3/4 porcelain/ceramic	$644	$210
D6784	Retainer crown - 3/4 titanium and titanium alloys	Not Covered	$285
D6790	Retainer crown - full cast high noble metal	$562	$310
D6791	Retainer crown - full cast predominantly base metal	$402	$160
D6792	Retainer crown - full cast noble metal	$517	$285
D6793	Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$244	$200
D6794	Retainer crown - titanium and titanium alloys	$559	$310
D6930	Re-cement or re-bond fixed partial denture	$86	$15
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.			
D7111	Extraction, coronal remnants - primary tooth	$62	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$96	$5
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$129	$30
D7220	Removal of impacted tooth - soft tissue	$184	$40
D7230	Removal of impacted tooth - partially bony	$183	$60
D7240	Removal of impacted tooth - completely bony	$211	$90
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$257	$105
D7250	Removal of residual tooth roots (cutting procedure)	$142	$40
D7251	Coronectomy - intentional partial tooth removal	$283	$90
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$300	$150
D7280	Exposure of an unerupted tooth	$300	$90
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$275	$225

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D7283	Placement of device to facilitate eruption of impacted tooth	$162	$90
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$354	$80
D7286	Incisional biopsy of oral tissue-soft	$209	$80
D7288	Brush biopsy - transepithelial sample collection	$115	$30
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$161	$30
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$114	$30
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$206	$30
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$153	$30
D7510	Incision and drainage of abscess - intraoral soft tissue	$110	$0
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$130	$100
D7961	Buccal/labial frenectomy (frenulectomy)	$272	$124
D7962	Lingual frenectomy (frenulectomy)	$272	$124
D7963	Frenuloplasty	$309	$124
D7970	Excision of hyperplastic tissue - per arch	$294	$146
D7971	Excision of pericoronal gingiva	$174	$35
D8000-D8999 XI. ORTHODONTICS - Not Covered			
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$68	$10
D9120	Fixed partial denture sectioning	$78	$35
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$34	$0
D9211	Regional block anesthesia	$26	$0
D9212	Trigeminal division block anesthesia	$68	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$20	$0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$87	$20
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0	$0
D9440	Office visit - after regularly scheduled hours	$50	$50

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D9450	Case presentation, detailed and extensive treatment planning	$0	$0
D9610	Therapeutic parenteral drug, single administration	$27	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$56	$30
D9613	Infitration of sustained release drug - single or multiple sites	Not Covered	$0
D9630	Drugs or medicaments dispensed in the office for home use	$25	$25
D9910	Application of desensitizing medicament	$20	$20
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not Covered	$20
D9932	Cleaning and inspection of removable complete denture, maxillary	$41	$25
D9933	Cleaning and inspection of removable complete denture, mandibular	$48	$25
D9934	Cleaning and inspection of removable partial denture, maxillary	$31	$25
D9935	Cleaning and inspection of removable partial denture, mandibular	$29	$25
D9941	Fabrication of athletic mouthguard	$149	$100
D9942	Repair and/or reline of occlusal guard	$125	$90
D9943	Occlusal guard adjustment	$69	$15
D9944	Occlusal guard - hard appliance, full arch	Not Covered	$180
D9945	Occlusal guard - soft appliance, full arch	Not Covered	$180
D9951	Occlusal adjustment, limited	$83	$35
D9952	Occlusal adjustment, complete	$255	$75
D9961	Duplicate/copy patents records	Not Covered	$0
D9970	Enamel microabrasion	$59	$20
D9971	Odontoplasty - 1-2 teeth; includes removal of enamel projections	$76	$20
D9972	External bleaching - per arch - performed in office	$200	$200
D9973	External bleaching - per tooth	$126	$100
D9974	Internal bleaching - per tooth	$154	$100
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$200	$200
D9990	Certified translation or sign language services per vist	Not Covered	$0

CODE	SERVICE	Basic Copayment	Optional Enhanced Copayment
D9991	Dental case management - addressing appointment compliance barriers	$0	$0
D9992	Dental case management - care coordination	$0	$0
D9993	Dental case management - motivational interviewing	$0	$0
D9994	Dental case management - patient education to improve oral health literacy	$0	$0

NOTE: The procedures described and maximum allowances indicated on this table are subject to the terms of the contract and Delta Dental processing policies. Any procedure not listed on this schedule is not covered. This plan may be updated to be CDT compliant.

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

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

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.

2. Any procedure that in the professional opinion of the Contract Dentist:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**

   b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations for non-covered benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist except for Emergency Services as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription drugs.

13. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

14. Applies to Optional Enhanced Dental Plan only - myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944 & D9945 (occlusal guard).

DEFINITIONS

Terms when capitalized in this Plan booklet have defined meanings, given in the section below or throughout the booklet sections.

Appeal – is something you do if you disagree with a decision to deny a request for dental care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a service you think you should be able to receive.

Benefits – the dental services under this Plan to which you are entitled to receive.

Calendar Year – the 12 months of the year from January 1st through December 31st.

Claim Form – the standard form used to file a claim or request a Pre-Treatment Estimate.

Contract – the Agreement between INTER VALLEY HEALTH PLAN and Delta Dental of California for the Provision of Dental Services.

Contractholder – INTER VALLEY HEALTH PLAN

Cost-sharing – the amounts which may be charged to a Member as the Member's share of the cost for the provision of covered services. Cost sharing under this Plan consists of copayments listed in Attachment A.

Delta Dental Participating Provider (Participating Provider) – means a person licensed to practice dentistry when and where performed who has entered into a contract with Delta Dental agreeing to participate in this Plan and provide covered services in general dentistry to Members.

Emergency Service – means dental care furnished to a Member needed to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Effective Date – the original date the Plan starts. This date is given on this booklet's cover and Attachment A.

Member – a person with Medicare who is eligible to get covered services, who has enrolled with Inter Valley Health Plan Service To Seniors (HMO) or Desert Preferred Choice (HMO) and whose enrollment has been confirmed by CMS.

Non Participating Provider – a dentist who has not entered into an agreement with Delta Dental to be a Participating Provider under this Plan.

Plan – the Basic Dental Plan or Optional Enhanced Dental Plan which describes the Benefits, limitations, exclusions, terms and conditions of coverage for Members enrolled in Contractholder's Medicare Advantage Plan.

Plan Year – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. January 1, 2022 through December 31, 2022.

Pre-Treatment Estimate – an estimation of the allowable Benefits under the Plan for the services proposed.

Procedure Code – the Current Dental Terminology® (CDT) number assigned to a Single Procedure by the American Dental Association.

Reasonable – means that a Member exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Participating Provider to obtain Emergency Services and, in the event the Participating Provider is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Participating Provider.

Single Procedure – a dental procedure that is assigned a separate Procedure Code.

Specialist Services – means services performed by a licensed dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

Treatment in Progress – means any single dental procedure, as defined by the Procedure Code that has been started while the Member was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under the Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken.

Delta Dental is a registered mark of
Delta Dental Plans Association.

Call a Delta Dental Customer Services Representative at 855-370-3801 (TTY users 711)

Inter Valley Health Plan
Medicare plans for health. Not for profit.

Contact our Member Care Team: 1-800-251-8191, TTY users should call 711.

Pharmacy Care Team: 1-800-523-3142, TTY users should call 711.

Contact us October 1 to March 31, 8 am to 8 pm, 7 days a week. We are closed on Thanksgiving Day and Christmas Day.

Contact us April 1 – September 30, 8 am to 8 pm, Monday through Friday. We are closed on federal holidays.

NOTE: When we are closed you have the option to leave a message. Messages received will be returned within one (1) business day.

You can see our plan's provider/pharmacy directory on our website at ivhp.com.