

Delta Dental of California Federal Services Division

Dentist Handbook



About this Handbook

This handbook is designed to assist dental offices in providing services to enrollees of dental programs administered by Delta Dental of California's Federal Services division, such as the TRICARE Retiree Dental Program. We welcome suggestions and recommendations that would make this handbook more valuable for you and your office in providing services to enrollees of these federal programs.

Dentist Networks for Delta Dental Federal Programs

Some programs administered by Delta Dental's Federal Services division allow enrollees the option of choosing any licensed dentist or selecting a dentist from a broad network of participating dentists. Other federal programs require enrollees to select from a specific network of dentists. The various Delta Dental dentist networks that are available to provide services under one or more of these federal dental programs are described below.

Delta Dental Premier® Network

Delta Dental Premier network dentists are "participating" dentists in Delta Dental's fee-for-service group programs that allow enrollees to visit any licensed dentist but that offer advantages such as no balance billing and the convenience of claims submission when enrollees select a contracting Delta Dental Premier dentist.

Delta Dental PPOSM/DPO Network

Delta Dental's PPO (preferred provider organization) dentists are "participating" dentists in Delta Dental's fee-for-service group programs that allow enrollees to visit any licensed dentist but offer incentives when choosing PPO network dentists. Dentists who contract with Delta Dental as PPO dentists agree to provide services at fees that meet the program's cost management criteria. In Texas, this network is known as a dental provider organization, or "DPO."

Delta Dental Legion Network (formerly Delta Dental Select Network)

This is one of the two networks that comprise the TRICARE Retiree Dental Program (TRDP) participating dentist network. The other is the Delta Dental PPO/DPO network. At the inception of the TRDP in 1998, the Delta Dental Legion network was the only network for TRDP enrollees, and it continues to be exclusive to the TRDP. With the renewal of the TRDP contract in May 2003, the Delta Dental PPO/DPO network was added as a participating dentist network.

Changes to Your Dentist Record

To ensure accurate and timely claims payment as well as a correct listing in the online Dentist Directory, it is important that you keep information regarding your network agreement current and that you update your contact and billing information as needed. If you participate in the Delta Dental Legion network, you must contact Delta Dental of California's Federal Services division with any changes. If you participate in the Delta Dental Premier network and/or the Delta Dental PPO/DPO network, contact your local Delta Dental member company. Please allow 30 days from the time changes are requested for them to be reflected in each of the Delta Dental files.

Delta Dental Legion Dentists

To request changes to your Delta Dental Legion participating dentist network agreement, such as changes in your office address, business name, tax identification number (TIN) or other information affecting the accurate processing of claims, please write or fax your request to the address below:

Delta Dental of California
Federal Services
PO Box 537007
Sacramento, CA 95853-7007
Fax: 916-858-0235

Delta Dental PPO/DPO and Delta Dental Premier Dentists

To request changes to your Delta Dental PPO/DPO or Delta Dental Premier dentist agreement, please contact your local Delta Dental member company. Contact information for each of the local Delta Dental member companies is provided for your convenience in the "Reference" section of this handbook.

Reference

The TRICARE Retiree Dental Program (TRDP)

Table of Contents

PROGRAM OVERVIEW	1-1
THE TRDP PARTICIPATING DENTIST NETWORK	2-1
HELPING YOUR TRDP PATIENTS GET STARTED	3-1
Notes about the TRDP	3-1
ELIGIBILITY FOR THE TRDP	4-1
Who is Eligible	4-1
Verifying Patient Eligibility	4-1
Enrollee ID Card	4-1
ENHANCED TRDP BENEFITS - GROUP 4601/4602	5-1
Overview of Enhanced TRDP Benefits	5-1
Enhanced TRDP Maximums and Deductible	5-2
Annual Maximum	5-2
Annual Maximum for Dental Accident Coverage	5-2
Lifetime Maximum for Orthodontic Procedures	5-2
Annual Deductible	5-2
Enhanced TRDP Benefit Waiting Period	5-3
Enhanced TRDP Benefit Time Limitations	5-3
Enhanced TRDP General Policies	5-3
Enhanced TRDP Covered Services	5-4
Diagnostic Services	5-4
Preventive Services—100% coverage	5-6
Preventive Services—80% coverage	5-6
Restorative Services	5-7
Major Restorative Services	5-8
Endodontic Services	5-10
Periodontic Services	5-12
Prosthodontic Services, Removable and Fixed	5-13
Implant Services	5-16
Oral Surgery Services	5-17
Orthodontic Services	5-19
Adjunctive General Services	5-20
Emergency Services—100% Coverage	5-20
Emergency Services—80% Coverage	5-20
Anesthesia	5-20
Professional Consultation	5-21
Professional Visits	5-21
Drugs	5-22
Post-Surgical Services	5-22
Miscellaneous Services	5-22
Exclusions	5-23
Dental Accident Coverage	5-24

Orthodontic Coverage	5-24
Orthodontic Claims Processing and Payments	5-25
Patient Eligibility	5-28
Dentist Status	5-28

BASIC TRDP BENEFITS - GROUP 4600

6-1

Overview of Basic TRDP Benefits	6-1
Basic TRDP Maximum and Deductible	6-1
Annual Maximum	6-1
Annual Deductible	6-2
Basic TRDP Benefit Time Limitations	6-2
Basic TRDP General Policies	6-2
Basic TRDP Covered Services	6-3
Diagnostic Services	6-3
Preventive Services—100% Coverage	6-5
Preventive Services—80% Coverage	6-5
Restorative Services	6-6
Endodontic Services	6-8
Periodontic Services	6-9
Oral Surgery Services	6-10
Adjunctive General Services	6-11
Emergency Services—100% coverage	6-11
Emergency Services—80% coverage	6-12
Drugs	6-12
Post-Surgical Services	6-13
Exclusions	6-13

CLAIMS

7-1

Claims Submission	7-1
When to File Claims	7-1
Where to File Claims	7-1
Claims Requiring Documentation	7-1
Claims Requiring X-rays	7-2
Requests for Additional Information	7-2
Predetermination Requests	7-2
Claims Payment	7-2
Waiver of Copayment	7-3
Coordination of Benefits	7-3
Birthday Rule	7-4
Custody Cases	7-4

DENTAL OFFICE TOOLKIT®

8-1

Overview of the Dental Office Toolkit®	8-1
Security	8-1
Password Protection	8-1
Encrypted Transmissions	8-2
Physical Protection	8-2
Direct Deposit	8-2

GLOSSARY

9-1

TRDP NEWSLETTERS

Program Overview

The TRICARE Retiree Dental Program (TRDP) is the only dental benefits program authorized by the U.S. government for over four million Uniformed Service retirees and their families. The Federal Services division of Delta Dental of California administers the TRDP under contract with the Department of Defense.

The TRDP began February 1, 1998, offering enrollees coverage under the Basic TRDP for limited basic and preventive services. On October 1, 2000, the scope of coverage and benefit structure of the TRDP was redesigned, offering a more comprehensive Enhanced Program that today includes benefits for major restorative, prosthetic, orthodontic and dental accident services.

New enrollments in the Basic TRDP ended August 31, 2000. However, Basic TRDP coverage continues for those who were enrolled prior to September 1, 2000 and who have elected not to upgrade to the Enhanced TRDP. Enrollments on or after September 1, 2000 are for the Enhanced TRDP only.

Additional changes to the TRDP became effective on May 1, 2003. Further program enhancements, including the addition of dental implant services to the Enhanced Program scope of benefits and the extension of the same comprehensive coverage under the new Enhanced-Overseas Program to enrollees living outside the designated service area, took effect with the start of the new TRDP contract on October 1, 2008.

Many of the same covered services and program policies apply to enrollees in both the Basic and Enhanced/Enhanced-Overseas TRDP. Others pertain only to those enrolled in the Enhanced and Enhanced-Overseas TRDP. We have included updated information on all three programs to help you better serve your TRDP patients.

The TRDP Participating Dentist Network

The TRDP is a national group dental benefits program for retirees of the Uniformed Services and their family members, with dentists in two Delta Dental networks who are considered participating dentists for the TRDP. Although the TRDP is structured as a PPO (preferred provider organization) that enables enrollees to seek care from any licensed dentist within the program's designated network service area, the program encourages enrollees to seek their care from a participating TRDP network dentist in either the Delta Dental Legion (formerly Delta Dental Select) or Delta Dental PPO/DPO network, available in more than 100,000 dentist locations nationwide.

Dentists may participate in either one of the networks serving the TRDP, or they may participate in both networks. A dentist from one or both participating TRDP networks who provides care to an enrollee in the TRDP is paid directly by Delta Dental. Payment is based on the dentist's fee arrangement with the TRDP or the local Delta Dental member company, if applicable, and based on Delta Dental national processing policies.

Not all Delta Dental dentists participate in the TRDP networks. For example, Delta Dental Premier® dentists are Delta Dental dentists who are not part of the participating TRDP networks. When an enrollee receives care from a Delta Dental Premier® dentist, Delta Dental will still send payment directly to the dentist. Payment made to Delta Dental Premier® dentists is based on the program's fee schedule for out-of-network services, but all fee provisions of the dentist's agreement with the local Delta Dental member company apply.

A participating network dentist may not collect payment from an enrollee/patient for any services excluded from benefits unless the enrollee/patient has been informed that services are non-covered benefits of the TRDP and the enrollee/patient has agreed, in advance of the service being performed, to pay for the services. This "agreement" must be evidenced in writing noting the specific services and must be signed and dated by both parties.

Many of your questions about the TRDP can be answered in this handbook or on our web site at www.trdp.org. If you are unable to find the answer to your question using either of these resources, please direct your question as follows:

Written Inquiries

Delta Dental of California
Federal Services
PO Box 537008
Sacramento, CA 95853-7008

Online Inquiries

www.trdp.org

Telephone Inquiries

Toll-free: 888-838-8737

Interactive Voice Response (IVR) System
24 hours a day, 7 days a week

Customer Service
Monday – Friday (excluding holidays)
6:00 a.m. – 6:00 p.m. (Pacific Time)

Helping Your TRDP Patients Get Started

All TRDP sponsors (primary enrollees) receive a Benefits Booklet detailing the covered services and policies of the program in which they are enrolled (Basic Program or Enhanced Program). Enrollees in the Enhanced-Overseas Program receive the Benefits Booklet for the Enhanced Program along with a supplement outlining TRDP guidelines that apply specifically to these overseas enrollees.

You can assist your TRDP patients in getting the most from their coverage by:

- Reading the information contained in this section of your Delta Dental Federal Services Dentist Handbook
- Reviewing the TRDP benefits sections of the handbook. In addition to a complete list of covered services, each section provides valuable information on TRDP benefit policies and exclusions, coverage levels, deductibles, maximums, and waiting periods. Although TRDP enrollees are encouraged to know their benefits, you and your staff may need to answer enrollees' question about the TRDP to help them better understand their coverage.
- Asking for the following information:
 - What is his or her TRDP group number? This number can be found on the patient's TRDP identification card. Enrollees in the Basic TRDP are assigned to group number 4600. Enrollees in the Enhanced TRDP are assigned to group number 4601. Enrollees in the Enhanced-Overseas TRDP are assigned to group 4602.
 - What is the retired sponsor's social security number?
 - What are the dates of birth of both the retired sponsor and the patient?
 - Does the retired sponsor/patient have another dental plan? If so, who is the primary enrollee in the other dental plan?
- Verifying your TRDP patient's eligibility prior to providing treatment. Verification of eligibility by contacting Delta Dental at 888-838-8737 or by using the Dental Office Toolkit® at www.trdp.org is recommended, as possession of an identification card does not guarantee that the enrollee is currently enrolled in the TRDP.

Notes about the TRDP

- As of October 1, 2008, enrollees in the TRDP are in one of three benefit programs: the Basic TRDP (Group 4600), the Enhanced TRDP (Group 4601), or the Enhanced-Overseas TRDP (Group 4602). The benefits of these programs can differ, so it is important to verify your TRDP patient's eligibility and program coverage before providing treatment. This handbook provides sections that include more detailed information about the coverage levels of each program.
- The benefit year for the annual maximum and deductible runs from October 1 through September 30.
- Predeterminations are not required; however, they are recommended for more complex or costly treatment plans.
- Certain covered procedures are subject to applicable waiting periods and/or time limitations based on the date of service.
- Certain covered procedures require radiographs or documentation in order to process the claim. These are noted in the sections in this handbook that outline the covered services, general policies, limitations and exclusions for the Basic and Enhanced Programs. Please refer to these sections to avoid sending radiographs or documentation unnecessarily.

- Inquiries regarding the TRDP:

Claim Submission

Delta Dental of California
Federal Services
PO Box 537007
Sacramento, CA 95853-7007

Written Inquiries

Delta Dental of California
Federal Services
PO Box 537008
Sacramento, CA 95853-7008

Online Inquiries

www.trdp.org

Telephone Inquiries

888-838-8737

Interactive Voice Response (IVR) System

24 hours a day, 7 days a week.

Customer Service

Monday - Friday (excluding holidays)
6:00 a.m. - 6:00 p.m. Pacific Time

- The TRDP web site at www.trdp.org has valuable information and convenient self-service tools for dentists. In particular, the online Dental Office Toolkit® allows you to verify patient eligibility and benefit levels, check claims status, submit claims electronically, and much more. See the “Dental Office Toolkit” section at the end of this handbook for more detailed information about this feature.

Eligibility for the TRDP

Who is Eligible

The federal government defined eligibility requirements for enrollment in the TRDP in the law that established the program. To learn more about specific eligibility requirements for the TRDP, please visit our web site at www.trdp.org.

Coverage under the Basic and Enhanced TRDP is limited to treatment provided to eligible enrollees in the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada.

Uniformed Services retirees and their family members who live permanently outside the area described above are eligible for comprehensive coverage offered under the Enhanced-Overseas TRDP. The service area for enrollees in the Enhanced-Overseas TRDP is worldwide and includes the 50 United States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands and Canada as well as all other countries, provinces, territories and/or districts outside this area.

Verifying Patient Eligibility

For each TRDP claim that is submitted, Delta Dental verifies the patient's eligibility against TRDP enrollment data. If there is no record of current eligibility for your patient, Delta Dental must deny the claim.

Your patients enrolled in the TRDP are eligible for either basic or enhanced benefits; therefore, it is recommended that you verify your patient's eligibility for the program in which they are enrolled before beginning treatment.

To verify a patient's eligibility and program type prior to treatment, use one of the following methods. You must have the patient's name and date of birth, and the retired sponsor's social security number to obtain eligibility information.

- For prompt service, verify eligibility online by using the Dental Office Toolkit® at www.trdp.org. See the "Dental Office Toolkit" section of this handbook for additional information.
- Eligibility may also be checked through our toll-free automated Interactive Voice Response (IVR) system at 888-838-8737, available 24 hours a day, seven days a week. Eligibility information can be obtained through automated voice response or sent by fax to your office.
- Customer Service associates are available toll-free at 888-838-8737, Monday through Friday from 6:00 a.m. to 6:00 p.m. Pacific Time.

Enrollee ID Card

Enrollees receive a membership identification card upon their initial enrollment in the TRDP. An enrollee's ID card does not guarantee that he or she is currently enrolled in the TRDP; therefore, verification of eligibility is recommended. The back of the ID card provides information on how to contact us to verify eligibility.

Enhanced TRDP Benefits - Group 4601/4602

Overview of Enhanced TRDP Benefits

The table below provides an overview of services covered under the Enhanced TRDP (Group 4601) and Enhanced-Overseas TRDP (Group 4602). The Enhanced TRDP is designed to allow enrollees to receive many covered services immediately upon their coverage effective date and additional services after 12 months of continuous enrollment. A list of all services covered under this program, including applicable procedure codes, can be found under “Enhanced TRDP Covered Services.” If you are not sure of your patient’s coverage, please call Delta Dental at 888-838-8737 to verify eligibility prior to providing treatment. See the “Verifying Patient Eligibility” section for more information.

Type of Service	Percent of Allowed Amount	
	†First 12 months of continuous enrollment	After 12 months of continuous enrollment
Diagnostic	100%	100%
Preventive	80%-100%	80%-100%
Restorative	80%	80%
Major Restorative	Not a benefit	50%
Amalgam allowance for three- and four-surface posterior composite resins	80%	80%
Endodontics	60%	60%
Periodontics	60%	60%
Prosthodontics—removable and fixed	Not a benefit	50%
Implant Services	Not a benefit	50%
Oral Surgery	60%	60%
Orthodontics	Not a benefit	50%
Emergency Services	80%-100%	80%-100%
Anesthesia	60%	60%
Professional Consultation	60%	60%
Professional Visits	60%	60%
Drugs	60%	60%
Post-surgical Services	60%	60%
Miscellaneous Services	60%	60%
Dental Accident	100%	100%
Deductible*		
Per patient, per benefit year	\$50 (not to exceed \$150 per family)	
<i>*Diagnostic and preventive procedures covered at 100%, orthodontics and dental accident coverage are exempt from the deductible</i>		
Annual Maximum**		
Per patient, per benefit year	\$1,200	
<i>**Diagnostic and preventive procedures covered at 100% are exempt from the annual maximum</i>		
Separate Dental Accident Coverage Maximum		
Per patient, per benefit year	\$1,000	
Separate Orthodontic Maximum		
Per patient, per lifetime	\$1,500	

Enhanced TRDP Maximums and Deductible

Annual Maximum

The Enhanced TRDP has an annual maximum of \$1,200 per enrollee per benefit year (October 1 through September 30) for most covered services. Orthodontics, dental accident procedures, diagnostic services, and preventive services that are covered at 100 percent are not charged against the annual maximum. Orthodontics and dental accident procedures have separate maximum benefit amounts.

Enrollees receive a new \$1,200 annual maximum at the beginning of each benefit year. Any balance of the annual maximum remaining at the end of the benefit year does not carry over to the next year.

Services subject to the \$1,200 annual maximum include:

- Sealants and space maintainers
- Basic and major restorative services
- Endodontic and periodontic services
- Prosthodontic services
- Dental implant services
- Oral surgery, anesthesia, drugs and post-surgical services
- Emergency services
- Professional consultations and professional visits
- Miscellaneous services

Annual Maximum for Dental Accident Coverage

A separate \$1,000 annual maximum per enrollee for procedures provided as a result of a dental accident is allowed for each benefit year (October 1 through September 30) under the Enhanced TRDP. Any balance of the annual maximum for dental accident procedures remaining at the end of the benefit year does not carry over to the next year. The annual maximum for other services does not apply to dental accident procedures. See the section on Dental Accident Coverage for more information.

Lifetime Maximum for Orthodontic Procedures

A separate lifetime maximum of \$1,500 is allowed for each enrollee for covered orthodontic procedures. Eligibility for orthodontic coverage under the Enhanced TRDP extends to both children and adults. See the section on “Orthodontics” for additional information.

Annual Deductible

Each enrollee in the Enhanced TRDP must satisfy an annual deductible of \$50, not to exceed \$150 per family, every benefit year (October 1 through September 30). Annual deductible balances remaining at the end of the benefit year do not carry over to the next year.

Diagnostic services, preventive services covered at 100 percent, orthodontic services, and dental accident procedures are not subject to the annual deductible. The following pages of this handbook provide information on those services which are subject to the Enhanced TRDP annual deductible.

Enhanced TRDP Benefit Waiting Period

Certain services and procedures, including cast crowns, bridges, full and partial dentures, dental implants and orthodontics, have a 12-month waiting period. It is important that both the dentist and the patient are aware of this requirement.

Enhanced TRDP Benefit Time Limitations

Some TRDP benefits are subject to time limitations that specify how often the benefit can be paid. Time limitations state that certain services are covered no more than once or twice within a specified number of months (depending on the benefit). These limitations pertain to the period of time immediately preceding the date of the service being billed. This period is not affected by a calendar year, benefit year or enrollment year.

For example:

Two cleanings in a 12-month period are payable under the Enhanced TRDP. If Delta Dental paid for a cleaning performed on October 15, 2008 and a second cleaning performed on April 15, 2009, a third cleaning is not payable until October 16, 2009.

Enhanced TRDP General Policies

The following is a list of general policies that apply to the Enhanced TRDP. Since it is not possible to list every policy, it is recommended that you submit a request for predetermination prior to providing treatment if you have questions about your patient's coverage. All covered services listed in this section conform to the current version of the American Dental Association (ADA) Current Dental Terminology (CDT-2009/2010).

1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (non-covered services) for billing purposes.
2. Claims received on or after the first of the month following 12 months of the date of service are not payable by Delta Dental. The fees for Delta Dental's portion of the payment are not chargeable to the patient by a participating network dentist.
3. TRDP participating dentists have agreed not to charge the patient more than the deductible and/or cost-share amount as shown on the Explanation of Benefits.
4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.
5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.
6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).
7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.
8. Postoperative care and evaluation are included in the fee for the service.
9. The fee for medicaments/solutions is part of the fee for the total procedure.
10. Procedure codes may be modified by Delta Dental based on the description of service and supporting documentation.
11. For procedures limited to a specific frequency during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.
12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.
13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient's responsibility.

14. Covered procedures, except orthodontic procedures as described in this attachment, are payable only upon completion of the procedure billed.
15. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.
16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.
17. Effective July 1, 2007, the TRICARE medical plan implemented coverage for medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for pediatric patients age 5 and under (this general anesthesia benefit is not covered by the TRDP). Since preauthorization for this benefit is required, patients should contact their regional TRICARE Managed Care Support Contractor for specific instructions. Information is also available at www.tricare.mil.
18. An "R" to the right of the procedure code means "by report" and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits.
19. An "X" to the right of the procedure code means that these services will be paid only when a current radiograph is submitted with the dental claim.

Enhanced TRDP Covered Services

Diagnostic Services

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: No

Applies to Maximum: No

D0120	Periodic oral evaluation—established patient
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver
D0150	Comprehensive oral evaluation—new or established patient
D0160	Detailed and extensive oral evaluation—problem-focused
D0170	R Re-evaluation—limited, problem-focused (established patient; not post-operative visit)
D0180	Comprehensive periodontal evaluation—new or established patient
D0210	Intraoral—complete series (including bitewings)
D0220	Intraoral—periapical first film
D0230	Intraoral—periapical each additional film
D0240	Intraoral—occlusal film
D0250	Extraoral—first film
D0260	Extraoral—each additional film
D0270	Bitewing—single film
D0272	Bitewings—two films
D0273	Bitewings—three films
D0274	Bitewings—four films
D0277	Vertical bitewings—seven to eight films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0330	Panoramic film

D0340	Cephalometric film
D0425	R Caries susceptibility tests
D0460	Pulp vitality tests
D0470	Diagnostic casts

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.
2. Payment is limited to any two evaluations, comprehensive and/or periodic, in a 12-month period. Payment for more than two evaluations, comprehensive and/or periodic, in a 12-month period is the patient's responsibility. This limitation includes procedure D0145, "oral evaluation for a patient under three years of age and counseling with primary caregiver."
3. One comprehensive oral evaluation (D0150 - comprehensive oral evaluation, D0160 - detailed and extensive oral evaluation or D0180 - comprehensive periodontal evaluation) is payable once per dentist per year and only if related to covered dental procedures. Additional evaluations are considered periodic evaluations and are paid as such.
4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.
5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.
6. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.
7. A full-mouth series (complete series) of radiographs includes bitewings. Any additional film taken with a complete radiographic series is considered integral to the complete series.
8. A panoramic radiograph taken with any other film is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.
9. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.
10. Payment for more than one of any category of full-mouth radiographs within a 60-month period is the patient's responsibility. If a full-mouth series (complete series) is denied because of the 60-month limitation, it cannot be reprocessed and paid as bitewings and/or additional films.
11. Payment for panoramic radiograph is limited to one within a 60-month period.
12. Payment for periapical films (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.
13. Payment for a bitewing survey, whether single, two, three, four or vertical film(s), including those taken as part of a complete series, is limited to one within a 12-month period.
14. Radiographs of non-diagnostic quality are not payable.
15. Duplication of radiographs for administrative purposes is not payable.
16. Test reports must describe the pathological condition, type of study and rationale.
17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.
18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.
19. Detailed and extensive oral evaluations (D0160) are limited to once per patient per dentist, per year. They will not be paid if related to noncovered medical or dental procedures.
20. Re-evaluations (D0170) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to noncovered medical or dental procedures.
21. Two cephalometric films (D0340) or two facial bone films (D0290) or one of each film are payable for orthodontic diagnostic purposes only. The fee for additional films taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

22. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

Preventive Services—100% coverage

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: No

Applies to Maximum: No

D1110	Prophylaxis—adult (two per 12-month period)
D1120	Prophylaxis—child (two per 12-month period)
D1203	Topical application of fluoride—child
D1204	Topical application of fluoride—adult
D1206	Topical fluoride varnish, therapeutic application for moderate to high caries risk patients

Preventive Services—80% coverage

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D1351	Sealant—per tooth
D1510	Space maintainer—fixed - unilateral
D1515	Space maintainer—fixed - bilateral
D1520	Space maintainer—removable - unilateral
D1525	Space maintainer—removable - bilateral
D1550	Recementation of space maintainer
D1555	Removal of fixed space maintainer

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.
2. Two prophylaxes for both adults and children are covered in a period of 12 consecutive months. This limitation includes periodontal maintenance procedure D4910, which is covered at 60 percent. Payment is limited to two prophylaxes or one prophylaxis and one periodontal maintenance procedure or two periodontal maintenance procedures in 12 consecutive months. Payment for additional prophylaxes or periodontal maintenance procedures is the patient's responsibility.
3. Two fluoride treatments for both adults and children are covered in a period of 12 consecutive months. This limitation includes procedure D1206, "topical fluoride varnish; therapeutic application for moderate to high caries risk patients." Payment for additional fluoride treatments are the patient's responsibility.
4. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.
5. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.
6. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.

7. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.
8. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

The following policies apply to preventive services covered at 80%:

9. Sealants are only covered on permanent molars through age 18.
10. One sealant per tooth is covered in a three-year period.
11. Sealants are only payable for molars that are caries free with no previous restorations on the mesial, distal or occlusal surfaces.
12. Sealants for teeth other than permanent molars are not covered.
13. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.
14. Sealants are covered for prevention of occlusal pit and fissure type cavities. Sealants provided for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.
15. The tooth number of the space to be maintained is required when requesting payment for space maintainers.
16. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.
17. Only one space maintainer is paid for a space, except under unusual circumstances (where changes due to growth patterns or additional extractions make replacement necessary).
18. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.
19. Repair of a damaged space maintainer is not covered.
20. Recementation of space maintainers is payable once within 12 months.
21. Space maintainers are not covered for patients 14 years and older.
22. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by contractor or chargeable to the patient by a participating network dentist.

Restorative Services

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D2140	Amalgam—one surface, primary or permanent
D2150	Amalgam—two surfaces, primary or permanent
D2160	Amalgam—three surfaces, primary or permanent
D2161	Amalgam—four or more surfaces, primary or permanent
D2330	Resin-based composite—one surface, anterior
D2331	Resin-based composite—two surfaces, anterior
D2332	Resin-based composite—three surfaces, anterior
D2335	Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite— one surface, posterior
D2392	Resin-based composite—two surfaces, posterior
D2910	Recement inlay, onlay, or partial coverage restoration

D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D2930	Prefabricated stainless steel crown—primary tooth
D2931	Prefabricated stainless steel crown—permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2951	Pin retention—per tooth, in addition to restoration
D2970	R Temporary crown (fractured tooth)

Major Restorative Services

Coverage: 50% after 12 months

Patient Pays: 50% after 12 months

Subject to Deductible: Yes

Applies to Maximum: Yes

D2542	X Onlay—metallic - two surfaces
D2543	X Onlay—metallic - three surfaces
D2544	X Onlay—metallic - four or more surfaces
D2740	X Crown—porcelain/ceramic substrate
D2750	X Crown—porcelain fused to high noble metal
D2751	X Crown—porcelain fused to predominantly base metal
D2752	X Crown—porcelain fused to noble metal
D2780	X Crown—3/4 cast high noble metal
D2781	X Crown—3/4 cast predominantly base metal
D2782	X Crown—3/4 cast noble metal
D2783	X Crown—3/4 porcelain/ceramic
D2790	X Crown—full cast high noble metal
D2791	X Crown—full cast predominantly base metal
D2792	X Crown—full cast noble metal
D2794	X Crown—titanium
D2950	X Core buildup, including any pins
D2952	X Post and core in addition to crown, indirectly fabricated
D2954	X Prefabricated post and core in addition to crown
D2980	Crown repair

The following policies apply to restorative services covered at 80%:

1. Coverage is for basic restorative services of amalgam fillings, anterior composite restorations, and one and two surface posterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.
2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.
3. Replacement of a restoration by the same dentist or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.

4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents, gingivectomy, infection control and expenses for compliance with OSHA regulations, etc. is not payable.
5. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension, are not covered.
6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review.
7. Posterior restorations not involving the occlusal surface are paid as one-surface restorations, subject to review.
8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.
9. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.
10. Pin retention is payable once per restoration to the same dentist or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.
11. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 24 months is not covered.
12. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.
13. Pin retention and buildups on primary teeth are covered in the fee for the restoration.
14. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.
15. Recementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.
16. After six months from the initial cementation date, recementation of crowns is payable once within 12 months.
17. Payment for a temporary crown (D2970) will be made for a damaged tooth as an immediate protective device once per tooth per lifetime unless justified by treating dentist, by report.
18. An allowance for comparable amalgam restorations with a patient co-payment of 20% is allowed when the patient opts for the following resin procedure codes on posterior teeth. The patient is responsible for the difference between the dentist's charge for the posterior resin and the TRDP paid amount:

D2393 Resin-based composite - three surfaces, posterior

D2394 Resin-based composite - four or more surfaces, posterior

The following policies apply to major restorative services covered at 50% after 12 months:

19. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.
20. Facings on crowns posterior to the second molar position are considered to be cosmetic components. An allowance is made for a full cast crown.
21. After six months from the initial cementation date, recementation of cast crowns is payable once within 12 months.
22. Cast restorations are covered benefits only when necessary to replace natural tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension are not covered.

23. The charge for a crown or onlay is considered to include all charges for work related to its placement including, but not limited to, preparation of gingival tissue, tooth preparation, temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.
24. Onlays, permanent single crown restorations and necessary posts and cores for patients under 14 years of age are excluded from coverage unless specific rationale is provided indicating the reason for such treatment.
25. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup or post and core is not and cannot be made serviceable.
26. Temporary crowns placed in preparation for a permanent crown are considered integral to the placement of the permanent crown and are not payable as a separate procedure.
27. Recementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts within six months of placement by the same dentist is considered integral to the original procedure.
28. Onlays, crowns, and posts and cores are payable to restore a natural tooth due to decay or fracture. However, if the degree of breakdown does not qualify for a cast restoration, a benefit allowance will be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.
29. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown and are considered integral to the buildup.
30. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.
31. Cast restorations and substructures include pins. A separate fee is not covered.
32. Veneers are not covered benefits. An allowance will be made for a resin restoration on an anterior tooth based on the degree of breakdown.
33. Porcelain/ceramic inlays and onlays are not covered benefits. An optional benefit allowance toward a porcelain/ceramic inlay may be made with a corresponding amalgam restoration on a posterior tooth, and a resin restoration on an anterior tooth. An optional benefit allowance toward a porcelain/ceramic onlay may be made with a metallic onlay.
34. The completion date for crowns, onlays and buildups is the cementation date.
35. Resin or metallic inlays and resin onlays are not covered benefits. An optional benefit allowance may be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.
36. Glass ionomer restorations are not covered benefits.
37. Gold foil restorations are not covered benefits.
38. Cast crowns with resin facings are not covered benefits.

Endodontic Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D3120	Pulp cap—indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3222	Partial Pulpotomy for apexogenesis—permanent tooth with incomplete root development
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)

D3310	Root canal therapy—anterior (excluding final restoration)
D3320	Root canal therapy—bicuspid (excluding final restoration)
D3330	Root canal therapy—molar (excluding final restoration)
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3346	Retreatment of previous root canal therapy—anterior
D3347	Retreatment of previous root canal therapy—bicuspid
D3348	Retreatment of previous root canal therapy—molar
D3351	Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery—anterior
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)
D3425	Apicoectomy/periradicular surgery—molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling—per root
D3450	Root amputation—per root
D3920	Hemisection (including any root removal), not including root canal therapy

The following policies apply to endodontic services:

1. An indirect pulp cap is payable only when the final restoration is not completed for at least 60 days. An indirect pulp cap is included in the fee for the restoration when the restoration is placed in less than 60 days.
2. An indirect pulp cap is only payable once per tooth by the same dentist.
3. A direct pulp cap is included in the fee for the restoration or palliative treatment.
4. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist or group practice is to be included in the fee for the root canal therapy.
5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.
6. Endodontic procedures in conjunction with overdentures are not covered benefits.
7. The completion date for endodontic therapy is the date the tooth is sealed.
8. Retreatment of apical surgery or root canal therapy by the same dentist or group practice within 24 months is considered part of the original procedure.
9. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.
10. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a dentist not completing the endodontic therapy.
11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.
12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.
13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed with codes D3310 – D3330, D3346 – D3348, or D3351 – D3353 on the same day or within 30 days (same tooth/same provider/same office).

Periodontic Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D4210	R	Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	R	Gingivectomy or gingivoplasty—one to three contiguous teeth or bounded teeth spaces per quadrant
D4240	R	Gingival flap procedure, including root planing—four or more contiguous teeth or bounded teeth spaces per quadrant
D4241	R	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant
D4245	R	Apically positioned flap
D4249	X	Clinical crown lengthening—hard tissue
D4260	R	Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	R	Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bounded teeth spaces per quadrant
D4263	R	Bone replacement graft—first site in quadrant
D4264	R	Bone replacement graft—each additional site in quadrant
D4266	R	Guided tissue regeneration—resorbable barrier, per site
D4267	R	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)
D4270	R	Pedicle soft tissue graft procedure
D4271	R	Free soft tissue graft procedure (including donor site surgery)
D4273	R	Subepithelial connective tissue graft procedures, per tooth
D4341	R	Periodontal scaling and root planing—four or more teeth per quadrant
D4342	R	Periodontal scaling and root planing—one to three teeth per quadrant
D4355	R	Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4910		Periodontal maintenance
D4920	R	Unscheduled dressing change (by someone other than treating dentist)

The following policies apply to periodontic services:

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/ quadrants/teeth involved and is required for most procedures.
2. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.
3. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.
4. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.
5. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.
6. Osseous, gingival and synthetic grafts must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis.
7. Bone grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.

8. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.
9. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same dentist.
10. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.
11. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.
12. Full-mouth debridement is a benefit once per patient per lifetime.
13. One crown lengthening per tooth, per lifetime, is covered.
14. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same dentist, and in the same area of the mouth, will be processed as crown lengthening.
15. Subepithelial connective tissue grafts are payable at the level of free soft tissue grafts.
16. An apically positioned flap is subject to documentation when performed and when not related to implants.

Prosthodontic Services, Removable and Fixed

Coverage: 50% after 12 months

Patient Pays: 50% after 12 months

Subject to Deductible: Yes

Applies to Maximum: Yes

Prosthodontics, Removable

D5110	Complete denture—maxillary
D5120	Complete denture—mandibular
D5130	Immediate denture—maxillary
D5140	Immediate denture—mandibular
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5410	Adjust complete denture—maxillary
D5411	Adjust complete denture—mandibular
D5421	Adjust partial denture—maxillary
D5422	Adjust partial denture—mandibular
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth—complete denture (each tooth)
D5610	Repair resin denture base—partial denture
D5620	Repair cast framework—partial denture
D5630	Repair or replace broken clasp—partial denture
D5640	Replace broken teeth—partial denture, per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture

D5670	Replace all teeth and acrylic on cast metal framework (maxillary)—partial denture
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)—partial denture
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5810	Interim complete denture (maxillary)
D5811	Interim complete denture (mandibular)
D5820	Interim partial denture (maxillary)
D5821	Interim partial denture (mandibular)
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular

Prosthodontics, Fixed

D6210	X Pontic—cast high noble metal
D6211	X Pontic—cast predominantly base metal
D6212	X Pontic—cast noble metal
D6214	X Pontic—titanium
D6240	X Pontic—porcelain fused to high noble metal
D6241	X Pontic—porcelain fused to predominantly base metal
D6242	X Pontic—porcelain fused to noble metal
D6245	X Pontic—porcelain/ceramic
D6545	X Retainer—cast metal for resin bonded fixed prosthesis
D6548	X Retainer—porcelain/ceramic for resin bonded fixed prosthesis
D6610	X Onlay—cast high noble metal, two surfaces
D6611	X Onlay—cast high noble metal, three or more surfaces
D6612	X Onlay—cast predominantly base metal, two surfaces
D6613	X Onlay—cast predominantly base metal, three or more surfaces
D6614	X Onlay—cast noble metal, two surfaces
D6615	X Onlay—cast noble metal, three or more surfaces
D6634	X Onlay—titanium
D6740	X Crown—porcelain/ceramic
D6750	X Crown—porcelain fused to high noble metal
D6751	X Crown—porcelain fused to predominantly base metal
D6752	X Crown—porcelain fused to noble metal
D6780	X Crown—3/4 cast high noble metal
D6781	X Crown—3/4 cast predominantly base metal
D6782	X Crown—3/4 cast noble metal
D6783	X Crown—3/4 porcelain/ceramic

D6790	X	Crown—full cast high noble metal
D6791	X	Crown—full cast predominantly base metal
D6792	X	Crown—full cast noble metal
D6794	X	Crown—titanium
D6930		Recement fixed partial denture
D6970	X	Post and core in addition to fixed partial denture retainer, indirectly fabricated
D6972	X	Prefabricated post and core in addition to fixed partial denture retainer
D6973	X	Core build-up for retainer, including any pins
D6980	R	Fixed partial denture repair

The following policies apply to prosthodontic services, removable and fixed:

1. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures is included in the fee for these procedures.
2. Removable cast base partial dentures for patients under 16 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment.
3. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.
4. Tissue conditioning is limited to twice per denture within 36 months.
5. Payment for the replacement of missing natural teeth will be made up to the normal complement of natural teeth. Additional pontics are optional and, if placed should be done with the agreement of the patient to assume the additional cost. (Benefits for pontics are based on the number necessary for the spaces, not to exceed the number of missing teeth.)
6. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.
7. Cast restorations and substructures include pins.
8. After six months from the initial recementation date, recementation of fixed partial dentures, inlays or onlays is payable once within 12 months.
9. The permanent cementation date is considered to be the completion date for crowns and fixed bridges.
10. Adjustments provided within six months of the insertion of an initial or replacement denture are integral to the denture.
11. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.
12. A reline/rebase is covered once in any 36 months.
13. The fee for the complete replacement of denture base material (rebase) includes a reline.
14. Reline or rebase of an existing appliance will not be covered when such procedures are performed in addition to a new denture for the same arch.
15. Fixed partial dentures, buildups, and posts and cores for patients under 16 years of age are not covered unless specific rationale is provided indicating the necessity of such treatment.
16. Payment for a denture made with precious metals or an overdenture is based on the allowance for a conventional denture. Payment for flexible base partials is based on the allowance for a resin based partial denture.
17. Specialized procedures performed in conjunction with an overdenture are not covered.
18. Cast unilateral removable partial dentures are not covered benefits.
19. Precision attachments, personalization, precious metal bases and other specialized techniques are not covered benefits.
20. The completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances.
21. Temporary fixed partial dentures are not a covered benefit when done in conjunction with permanent fixed partial dentures and are considered integral to the allowance for the fixed partial dentures.

22. Interim removable partial dentures are a benefit only to replace permanent anterior teeth during the healing period. Interim complete dentures are a benefit only under extenuating circumstances such as jaw or cancer surgery.
23. Repair of temporary appliances is not a covered benefit.
24. A posterior fixed bridge and partial denture in the same arch are not a benefit. Benefit is limited to the allowance for the partial denture.
25. The total allowed fee for repairs including rebases and relines should not exceed half of the allowed amount for a new prosthesis.
26. Fixed partial denture repairs (D6980) are payable by report with documentation of tooth numbers, type of appliance and description of repair.
27. Prosthodontic services are not benefits for patients under age 16 unless specific rationale is provided indicating the necessity of such treatment.
28. Substructures in connection with fixed prosthetics are a benefit once in five years per tooth. Payment for additional procedures is the patient's responsibility.
29. Replacement of a removable prosthesis (D5110 through D5214) or fixed prosthesis (D6210 through D6792) is covered only if the existing prosthesis was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing prosthesis cannot be made serviceable.
30. Porcelain/ceramic inlays and onlays are not covered benefits. An optional benefit allowance toward a porcelain/ceramic inlay may be made with a corresponding amalgam restoration on a posterior tooth, and a resin restoration on an anterior tooth. An optional benefit allowance toward a porcelain/ceramic onlay may be made with a metallic onlay. Any amount greater than the allowance is the patient's responsibility.
31. Fees for specialized techniques and characterization of dentures are the patient's responsibility.

Implant Services

Coverage: 50% after 12 months

Patient Pays: 50% after 12 months

Subject to Deductible: Yes

Applies to Maximum: Yes

D6010	Surgical placement of implant body: endosteal implant
D6050	Surgical placement: transosteal implant
D6056	Prefabricated abutment—includes placement
D6057	Custom abutment—includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078	Implant/abutment supported fixed denture for completely edentulous arch
D6079	Implant/abutment supported fixed denture for partially edentulous arch
D6090	R Repair implant supported prosthesis
D6094	Abutment supported crown (titanium)
D6095	R Repair implant abutment
D6194	Abutment supported retainer crown for FPD (titanium)

The following policies apply to implants:

1. Implant services are subject to a 50 percent cost-share and the annual program maximum.
2. Implant services are not eligible for members under age 16 unless submitted with x-rays and approved by Delta Dental.
3. Implants are not covered when placed for a removable denture.
4. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.
5. Replacement of an implant prosthesis is covered only if the existing prosthesis was placed at least five years prior to the replacement and satisfactory evidence is presented that demonstrates it is not, and cannot be made, serviceable.
6. Repair of an implant supported prosthesis (D6090) and repair of an implant abutment (D6095) are only payable by report upon Delta Dental dentist advisor review. The report should describe the problem and how it was repaired.

Oral Surgery Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	X Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	X Removal of impacted tooth—soft tissue
D7230	X Removal of impacted tooth—partially bony
D7240	X Removal of impacted tooth—completely bony
D7250	X Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth

D7285	R	Biopsy of oral tissue—hard (bone, tooth)
D7286	R	Biopsy of oral tissue—soft
D7290	R	Surgical repositioning of teeth
D7291	R	Transseptal fiberotomy/supra crestal fiberotomy
D7310		Alveoplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7311		Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant
D7320		Alveoplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7321		Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant
D7471		Removal of lateral exostosis (maxillary or mandibular)
D7472		Removal of torus palatinus
D7473		Removal of torus mandibularis
D7485		Surgical reduction of osseous tuberosity
D7510		Incision and drainage of abscess—intraoral soft tissue
D7511	R	Incision and drainage of abscess—intraoral soft tissue— complicated (includes drainage of multiple fascial spaces)
D7910	R	Suture of recent small wounds—up to 5 cm
D7911	R	Complicated suture—up to 5 cm
D7912	R	Complicated suture—greater than 5 cm
D7971		Excision of pericoronal gingiva
D7972		Surgical reduction of fibrous tuberosity

The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.
2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.
3. All hospital costs and any additional fees charged by the dentist arising from procedures rendered in the hospital are the patient's responsibility.
4. Surgical removal of impactions is payable according to the anatomical position.
5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.
6. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.
7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.
8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.
9. Excision of pericoronal gingiva is payable once per tooth.
10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.
11. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.
12. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.
13. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.
14. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.

Orthodontic Services

Coverage: 50% after 12 months

Patient Pays: 50% after 12 months

Subject to Deductible: No

Applies to Maximum: Yes (separate, lifetime maximum)

D8010	R	Limited orthodontic treatment of the primary dentition
D8020	R	Limited orthodontic treatment of the transitional dentition
D8030	R	Limited orthodontic treatment of the adolescent dentition
D8040	R	Limited orthodontic treatment of the adult dentition
D8050	R	Interceptive orthodontic treatment of the primary dentition
D8060	R	Interceptive orthodontic treatment of the transitional dentition
D8070	R	Comprehensive orthodontic treatment of the transitional dentition
D8080	R	Comprehensive orthodontic treatment of the adolescent dentition
D8090	R	Comprehensive orthodontic treatment of the adult dentition
D8210	R	Removable appliance therapy
D8220	R	Fixed appliance therapy
D8670	R	Periodic orthodontic treatment visit (as part of contract)
D8680	R	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690	R	Orthodontic treatment (alternative billing to a contract fee)

The following policies apply to orthodontic services:

1. Initial payment for orthodontic services will not be made until a banding date has been submitted.
2. All retention and case-finishing procedures are integral to the total case fee.
3. Observations and adjustments are integral to the payment for retention appliances. Repair of damaged orthodontic appliances is not covered.
4. Recementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is integral to the orthodontic appliance. However, recementation by a different dentist will be considered for payment as palliative emergency treatment.
5. The replacement of a lost or missing appliance is not a covered benefit.
6. Myofunctional therapy is integral to orthodontic treatment and not payable as a separate benefit.
7. Orthodontic treatment (alternative billing to contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.
8. Periodic orthodontic treatment visits (as part of contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service. Delta Dental uses this code when making periodic payments as part of the complete treatment plan payment.
9. It is the dentist's and the patient's responsibility to promptly notify Delta Dental if orthodontic treatment is discontinued or completed sooner than anticipated.
10. Post-operative orthodontic records including radiographs and models and records taken during treatment are included in the fee for the orthodontic treatment.
11. When a patient transfers to a different orthodontic dentist, payment and any additional charges involved with the transfer of an orthodontic case, such as changes in treatment plan, additional records, etc., will be subject to review and recalculation of benefits.
12. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

13. Two cephalometric films (D0340) or two facial bone films (D0290) or one of each film are payable for orthodontic diagnostic purposes. The fee for additional films taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

Adjunctive General Services

The TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

Emergency Services—100% Coverage

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: Yes

Applies to Maximum: Yes

D0140 Limited oral evaluation—problem focused

Emergency Services—80% Coverage

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9110 Palliative (emergency) treatment of dental pain—minor procedures

The following policies apply to emergency services:

1. Limited oral evaluation-problem-focused (D0140) must involve a problem or symptom that occurred suddenly and unexpectedly and requires immediate attention (emergency). This is paid as an emergency service and payment by Delta Dental is limited to one in a 12-month period for the same dentist. A limited oral evaluation does not count as one of the two evaluations, comprehensive and/or periodic, allowed in a 12-month period. Payment for additional D0140 evaluations in a 12-month period by the same dentist is the responsibility of the patient.
2. Emergency palliative treatment is payable on a per visit basis, once on the same date. All procedures necessary for relief of pain are included.
3. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

Anesthesia

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9220 R Deep sedation/general anesthesia—first 30 minutes

D9221 R Deep sedation/general anesthesia—each additional 15 minutes

D9241 R Intravenous conscious sedation/analgesia—first 30 minutes

D9242 R Intravenous conscious sedation/analgesia—each additional 15 minutes

The following policies apply to anesthesia services:

1. General anesthesia provides coverage by report only and for the administration of anesthesia provided in connection with a covered procedure(s).
2. General anesthesia (D9220, D9221) will be covered only by report and if determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
3. Intravenous sedation (D9241, D9242) will be covered only by report and in conjunction with covered procedures for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.
4. Payment is limited to when and if performed by a qualified dentist recognized by the state or jurisdiction in which he/she practices as authorized to perform IV sedation/general anesthesia.

Professional Consultation

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9310 R Consultation—diagnostic service provided by dentist or physician other than the requesting dentist or physician

The following policies apply to professional consultation:

1. Consultations reported for a non-covered procedure or condition, such as temporomandibular joint dysfunction, are not covered.

Professional Visits

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9440 Office visits—after regularly scheduled hours.

The following policies apply to professional visits:

1. After-hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the patient in an emergency situation.

Drugs

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9610 R Therapeutic parenteral drug, single administration

D9612 R Therapeutic parenteral drugs, two or more administrations, different medications

D9630 R Other drugs and/or medicaments

The following policies apply to coverage of drugs and medications:

1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.
2. The fee for medicaments/solutions is part of the fee for the total procedure.
3. Reimbursement for pharmacy-filled prescriptions is not a benefit.
4. Over the counter fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.
5. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

Post-Surgical Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9930 R Treatment of complications (post-surgical), unusual circumstances

The following policies apply to post-surgical services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

Miscellaneous Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9940 Occlusal guard

D9941 Fabrication of athletic mouthguard

D9974 Internal bleaching-per tooth

The following policies apply to miscellaneous services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.
2. Occlusal guards are covered for patients over the age of 12 for purposes other than TMJ treatment.
3. Athletic mouth guards are limited to one per 12-consecutive month period.
4. Payment for internal bleaching is limited to permanent anterior teeth and when performed in conjunction with root canal therapy.

Exclusions

The following services are not benefits under the Enhanced TRDP. Payment is the patient's responsibility. Since it is not possible to list every exclusion, it is recommended that if you have questions about your coverage, you should ask your dentist to submit a request for predetermination before your treatment begins.

1. Services for injuries or conditions that are covered under Worker's Compensation or Employer's Liability Laws.
2. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
3. Services, which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.
4. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
5. Those performed prior to the member's effective coverage date.
6. Those incurred after the termination date of the member's coverage unless otherwise indicated.
7. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.
8. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
9. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
10. Prescribed or applied therapeutic drugs, premedication, sedation, or analgesia.
11. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.
12. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.
13. Those not meeting accepted standards of dental practice.
14. Those which are for unusual procedures and techniques.
15. Plaque control programs, oral hygiene instruction, and dietary instruction.
16. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, and restoration for malalignment of teeth.
17. Gold foil restorations.
18. Premedication and inhalation analgesia.
19. House calls and hospital visits.
20. Telephone consultations.
21. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
22. Those resulting from the patient's failure to comply with professionally prescribed treatment.
23. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.

24. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
25. Duplicate and temporary devices, appliances, and services.
26. Experimental procedures.
27. All hospital costs and any additional fees charged by the dentist for hospital treatment.
28. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
29. Removal of implants.
30. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
31. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.
32. Treatment for routine dental services provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada unless enrolled in the Enhanced-Overseas Dental Program. An exception is made for full-time students studying overseas.
33. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.
34. Procedures not specifically listed are not payable, other than those modified by Delta Dental or those toward which an alternate benefit is provided by the program and as defined within the benefit policies.
35. Services submitted by a dentist, which are for the same services performed on the same date for the same member by another dentist.

Dental Accident Coverage

Accidents that cause injury to the mouth may result in a need for significant and expensive dental treatment. To help offset the cost of this treatment, dental accident coverage is included for enrollees under the Enhanced TRDP. Delta Dental pays 100 percent of the program allowed amount, subject to the annual dental accident maximum, for dental accident treatment described as follows:

Covered services for this program, excluding orthodontics, are subject to the general policies and exclusions applicable thereto, when provided for conditions caused directly or independently of all other causes, by external, violent and accidental means.

Dental accident benefits are limited to services provided to an eligible person within 180 days following the date of the accident. Dental accident benefits under the Enhanced TRDP do not include any services for conditions caused by an accident occurring before the enrollee's effective date of coverage. A separate maximum benefit amount of \$1,000 per enrollee per benefit year is allowed for dental accident coverage. The annual deductible does not apply to dental accident treatment.

The claim submitted to Delta Dental for payment of dental accident services must include a full narrative explanation by the dentist describing the accident and the resulting condition, the date of the accident and any supporting documentation.

Orthodontic Coverage

Orthodontic coverage is available for both children and adults enrolled in the Enhanced TRDP after the initial waiting period of 12 months. Orthodontic treatment is payable at 50 percent of the approved fee, subject to the lifetime orthodontic maximum of \$1,500 per patient payable by Delta Dental. For all Delta Dental Network Dentists, the approved fee is the network allowance and the patient can only be billed up to the approved fee. For non-Delta Dental dentists, the patient can be billed up to the submitted fee. Patients may request a predetermination (a non-binding estimate before treatment begins) to find out the amount Delta Dental will pay toward their orthodontic benefit. There is no annual deductible for orthodontic treatment. Payment for diagnostic services performed in conjunction with orthodontics is not applied to the enrollee's annual or lifetime maximums.

Orthodontic Claims Processing and Payments

Unlike other services which are payable upon completion, orthodontic services are payable over the course of treatment or 18 months, whichever is less. Claims for orthodontic treatment must include the following:

- Diagnosis
- Treatment plan, using current ADA codes
- All-inclusive total fee
- Banding/appliance placement date
- Estimated duration of active treatment

Only one claim with the above information should be submitted to Delta Dental. Delta Dental makes an initial payment for approved orthodontic claims, followed by three automatic progress payments at six-month intervals (or less if the active treatment is less than 18 months) as measured from the banding/appliance date, subject to continuing enrollment eligibility.

Cases Begun After Eligibility for Orthodontic Coverage

- If the estimated treatment plan is more than 18 months, the initial payment of 25 percent of the Total Amount Payable (TAP) is made upon processing of the initial claim. The remainder of the TAP is paid in three subsequent installments at six-month intervals from the banding date. For example:

Total approved fee	\$3400
Copayment for orthodontic coverage	50%
Maximum lifetime benefit allowed	\$1,500
Estimated length of active treatment	24 months
Banding month	January 2009
Completion month	December 2010
Multiply total approved fee by copayment ($\$3400 \times 50\%$)	\$1700
Lesser of balance (\$1,700) or orthodontic maximum (\$1,500),	\$1,500
Total amount payable by Delta Dental	\$1,500
Initial payment on 1/2009 ($\$1,500 \times 25\%$)	\$375
First progress payment on 6/2009	\$375
Second progress payment on 12/2009	\$375
Third progress payment on 6/2010	\$375

- If the estimated treatment plan is less than 18 months, the initial payment and three subsequent installments will be disbursed equally over this period. For example:

Total approved fee	\$1800
Copayment for orthodontic coverage	50%
Maximum lifetime benefit allowed	\$1,500
Estimated length of active treatment	14 months
Banding month	January 2009
Completion month	February 2010

Multiply total approved fee by copayment (\$1800 x 50%)	\$900
Lesser of balance (\$900) or orthodontic maximum (\$1,500),	\$900
Total amount payable by Delta Dental	\$900
Initial payment on 1/2009 (\$900 x 25%)	\$225
First progress payment on 5/2009	\$225
Second progress payment on 10/2009	\$225
Third progress payment on 2/2010	\$225

- If the TAP is no more than \$375, it is paid in a single, lump sum.

Cases Begun Prior to Eligibility for TRDP Orthodontic Coverage

When a patient becomes eligible for orthodontic coverage under the Enhanced TRDP after orthodontic treatment has already begun (known as “in-progress orthodontic treatment”), the TAP is prorated according to the remaining portion of active treatment scheduled as of the patient’s date of eligibility for orthodontic coverage. The following steps are taken by Delta Dental to determine payment for in-process treatment.

- The patient’s copayment for orthodontic coverage (50 percent) is applied to the treating dentist’s total approved fee. This determines the amount on which program payment is based.
- The resulting amount is multiplied by 30 percent to determine the banding fee payable at the time of placement.
- The banding fee is deducted from the amount on which program payment is based to determine the remaining amount payable.
- The remaining amount payable is prorated based on the number of months following the banding month, up to the patient’s date of enrollment in the Enhanced Program. This is used to calculate the TAP.

- The TAP is the lesser of the prorated payable amount and the lifetime orthodontic maximum allowed by the TRDP. The TAP is disbursed with an initial payment beginning with the patient's eligibility date, followed by three subsequent progress payments at six-month intervals. For example:

Total approved fee	\$5200
Copayment for orthodontic coverage	50%
Maximum lifetime benefit allowed	\$1,500
Estimated length of active treatment	24 months
Banding month	January 2009
Month patient is eligible for orthodontic coverage under the TRDP	June 2009
Completion month	December 2010
Number of months in active treatment remaining (6/2009–12/2010)	19 months

Multiply total approved fee by copayment ($\$5200 \times 50\%$)	\$2,600
Deduct banding fee ($2,600 \times 30\% = \$780$)	\$1,820
Lesser of prorated payable ($\$1,820 \times .826 = \$1,503.32$) or orthodontic maximum (\$1,500)	\$1,500
Total amount payable by Delta Dental	\$1,500
Initial payment on 6/2009 ($\$1,500 \times 25\%$)	\$375
First progress payment on 11/2009	\$375
Second progress payment on 5/2010	\$375
Third progress payment on 11/2010	\$375

- If the number of remaining treatment months is less than 18, the initial payment and three subsequent progress payments will be equally disbursed over this period.
- If the TAP is no more than \$375 it will be paid as a single, lump sum.

Patient Eligibility

Each orthodontic payment is subject to validation of the patient's enrollment status. Any progress payments are adjusted and/or discontinued accordingly.

- The patient must be enrolled in the Enhanced TRDP at the time the progress payment is scheduled. If a patient becomes eligible for orthodontic coverage after orthodontic treatment has already begun, payments are calculated as outlined under "Orthodontic Claims Processing and Payments."
- If the patient's enrollment in the Enhanced TRDP is terminated during the schedule of progress payments, no further progress payments are made.
- If a patient's enrollment in the Enhanced TRDP is terminated and the patient re-enrolls during the original schedule of progress payments, a new claim must be submitted at the time the patient becomes eligible for orthodontic coverage. Payments are made in accordance with the "Orthodontic Claims Processing and Payments" outlined in this handbook.

Dentist Status

Each orthodontic payment is also subject to validation of the dentist's status.

- If a dentist who does not participate in any Delta Dental network becomes either a dentist who participates in the TRDP network (Delta Dental Legion or Delta Dental PPO/DPO) or a Delta Dental Premier® USA dentist during the schedule of progress payments, the progress payments are sent directly to the dentist rather than to the patient. If a Delta Dental Legion, Delta Dental PPO/DPO or Delta Dental Premier® dentist discontinues participation as a Delta Dental dentist during the schedule of progress payments, the progress payments are sent to the patient.
- In the unlikely event that a dentist's license status changes (because of lost licensure or decertification by the federal government) during the schedule of progress payments, such payments would be discontinued as of the effective date of the loss of authorized status. In the case of federal program decertification, the patient is not liable for the subsequent fee charges unless a formal agreement is reached between the patient and the decertified dentist.

Basic TRDP Benefits - Group 4600

Overview of Basic TRDP Benefits

The following table provides an overview of services covered under the Basic TRDP (Group 4600). A list of all services covered under this program, including applicable procedure codes, can be found under “Basic TRDP Covered Services.” If you are not sure of your patient’s coverage, please call Delta Dental at 888- 838- 8737 to verify eligibility prior to providing treatment. See the “Verifying Patient Eligibility” section for more information.

Type of Service	Percent of Allowed Amount
Diagnostic	100%
Preventive	80%-100%
Restorative	80%
Endodontics	60%
Periodontics	60%
Oral Surgery	60%
Emergency Services	80%-100%
Drugs	60%
Post-surgical Services	60%
Deductible*	
Per patient, per benefit year	\$50 (not to exceed \$150 per family)
<i>*Diagnostic and preventive procedures covered at 100%, orthodontics and dental accident coverage are exempt from the deductible</i>	
Annual Maximum**	
Per patient, per benefit year	\$1,000
<i>**Diagnostic and preventive procedures covered at 100% are exempt from the annual maximum</i>	

Basic TRDP Maximum and Deductible

Annual Maximum

The Basic TRDP has an annual maximum of \$1,000 per enrollee per benefit year (October 1 through September 30) for most covered services. Diagnostic and preventive services covered by the TRDP at 100 percent are not charged against the annual maximum. Basic Program enrollees receive a new \$1,000 annual maximum at the beginning of each benefit year. Any balance of the annual maximum remaining at the end of the benefit year does not carry over to the next year.

Services of the Basic Program that are subject to the \$1,000 annual maximum include:

- Sealants and space maintainers
- Basic restorative services
- Endodontic and periodontic services
- Oral surgery, drugs and post-surgical services
- Emergency services
- Miscellaneous services

Annual Deductible

Each enrollee in the Basic TRDP must satisfy an annual deductible of \$50, not to exceed \$150 per family, every benefit year (October 1 through September 30). Annual deductible balances remaining at the end of the benefit year do not carry over to the next year.

Diagnostic and preventive services covered at 100 percent are not subject to the annual deductible. The pages of this handbook that follow provide information on the services that are subject to the Basic TRDP annual deductible.

Basic TRDP Benefit Time Limitations

Some TRDP benefits are subject to time limitations that specify how often a benefit can be paid. Time limitations state that certain services are covered no more than once or twice within a specified number of months (depending on the benefit). These limitations pertain to the period of time immediately preceding the date of the service being billed. This period is not affected by a calendar year, benefit year or enrollment year.

For example:

One cleaning per adult in a 12-month period is payable under the Basic TRDP. If Delta Dental paid for a cleaning performed on October 15, 2008, another cleaning would not be paid until October 16, 2009.

For more information regarding time limitations for covered services, please see the following sections.

Basic TRDP General Policies

The following is a list of general policies that apply to the Basic TRDP. Since it is not possible to list every policy, it is recommended that you submit a request for predetermination prior to providing treatment if you have questions about your patient's coverage. All covered services listed in this section conform to the current version of the American Dental Association (ADA) Current Dental Terminology (CDT-2009/2010).

1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (non-covered services) for billing purposes.
2. Claims received on or after the first of the month following 12 months of the date of service are not payable by Delta Dental. The fees for Delta Dental's portion of the payment are not chargeable to the patient by a participating network dentist.
3. Participating dentists must agree not to charge the patient more than the deductible and/or cost-share amount as shown on the Explanation of Benefits.
4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.
5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.
6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).
7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.
8. Postoperative care and evaluation are included in the fee for the service.
9. The fee for medicaments/solutions is part of the fee for the total procedure.
10. Procedure codes may be modified by Delta Dental based on the description of service and submitted supporting documentation.

11. For procedures limited to a certain frequency during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.
12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.
13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient's responsibility.
14. Covered procedures are payable only upon completion of the procedure billed.
15. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating dentists should document such notification in their records.
16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.
17. Effective July 1, 2007, the TRICARE medical plan implemented coverage for medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for pediatric patients age 5 and under (this general anesthesia benefit is not covered by the TRDP). Since preauthorization for this benefit is required, patients should contact their regional TRICARE Managed Care Support Contractor for specific instructions. Information is also available at www.tricare.mil.
18. An "R" to the right of the procedure code means "by report" and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits.
19. An "X" to the right of the procedure code means that these services will be paid only when a current radiograph is submitted with the dental claim.

Basic TRDP Covered Services

Diagnostic Services

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: No

Applies to Maximum: No

D0120	Periodic oral evaluation—established patient
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver
D0150	Comprehensive oral evaluation—new or established patient
D0160	Detailed and extensive oral evaluation—problem-focused
D0170	R Re-evaluation—limited, problem-focused (established patient; not post-operative visit)
D0180	Comprehensive periodontal evaluation—new or established patient
D0210	Intraoral—complete series (including bitewings)
D0220	Intraoral—periapical first film
D0230	Intraoral—periapical each additional film
D0240	Intraoral—occlusal film
D0270	Bitewing—single film

D0272	Bitewings—two films
D0273	Bitewings—three films
D0274	Bitewings—four films
D0277	Vertical bitewings—seven to eight films
D0330	Panoramic film
D0425	R Caries susceptibility tests
D0460	Pulp vitality tests

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.
2. Payment is limited to any two evaluations, comprehensive and/or periodic, in a 12-month period. Payment for more than two evaluations, comprehensive and/or periodic, in a 12-month period is the patient's responsibility. This limitation includes procedure D0145, "Oral evaluation for a patient under three years of age and counseling with a primary caregiver."
3. One comprehensive oral evaluation (D0150 - comprehensive oral evaluation, D0160 - detailed and extensive oral evaluation or D0180 - comprehensive periodontal evaluation) is payable once per dentist per year and only if related to covered dental procedures. Additional evaluations are considered periodic evaluations and are paid as such.
4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.
5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.
6. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.
7. A full-mouth series (complete series) of radiographs includes bitewings. Any additional film taken with a complete radiographic series is considered integral to the complete series.
8. A panoramic radiograph taken with any other film is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.
9. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.
10. Payment for more than one of any category of full-mouth radiographs within a 60-month period is the patient's responsibility. If a full-mouth series is denied because of the 60-month limitation, it cannot be reprocessed and paid as bitewings and/or additional films.
11. Payment for panoramic radiograph is limited to one within a 60-month period.
12. Payment for periapical films (other than as part of a full-mouth series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.
13. Payment for a bitewing survey, whether single, two, three, four or vertical film(s), including those taken as part of a complete series, is limited to one within a 12-month period.
14. Radiographs of non-diagnostic quality are not payable.
15. Duplication of radiographs for administrative purposes is not payable.
16. Test reports must describe the pathological condition, type of study and rationale.
17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.
18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

19. Detailed and extensive oral evaluations (D0160) are only payable by report upon review and are limited to once per patient per dentist, per lifetime. They will not be paid if related to noncovered medical or dental procedures.
20. Re-evaluations (D0170 R) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to non-covered medical or dental procedures.

Preventive Services—100% Coverage

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: No

Applies to Maximum: No

D1110	Prophylaxis—adult (one per 12-month period)
D1120	Prophylaxis—child (two per 12-month period)
D1203	Topical application of fluoride—child
D1204	Topical application of fluoride—adult
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

Preventive Services—80% Coverage

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D1351	Sealant—per tooth
D1510	Space maintainer—fixed - unilateral
D1515	Space maintainer—fixed - bilateral
D1520	Space maintainer—removable - unilateral
D1525	Space maintainer—removable - bilateral
D1550	Recementation of space maintainer
D1555	Removal of fixed space maintainer

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.
2. One prophylaxis for adults is covered in a period of 12 consecutive months. The limitation includes periodontal maintenance procedure D4910, which is covered at 60 percent. Payment is limited to one prophylaxis or one periodontal maintenance procedure in 12 consecutive months. Payment for additional prophylaxes or periodontal maintenance procedures is the patient's responsibility.
3. Two prophylaxes for children are covered in a period of 12 consecutive months.
4. One fluoride treatment for adults and two fluoride treatments for children are covered in a period of 12 consecutive months. This limitation includes procedure D1206, "topical fluoride varnish; therapeutic application for moderate to high caries risk patients." Payment for additional fluoride treatments are the patient's responsibility.
5. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.

6. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.
7. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.
8. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.
9. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

The following policies apply to preventive services covered at 80%:

10. Sealants are only covered on permanent molars through age 18.
11. One sealant per tooth is covered in a three-year period.
12. Sealants are only payable for molars that are caries free with no previous restorations on the mesial, distal or occlusal surfaces.
13. Sealants for teeth other than permanent molars are not covered.
14. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.
15. Sealants are covered for prevention of occlusal pit-and-fissure type cavities. Sealants done for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.
16. The tooth number of the space to be maintained is required when requesting payment for space maintainers.
17. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.
18. The fee for a space maintainer-type appliance done in conjunction with orthodontic treatment is not covered.
19. Only one space maintainer is paid for a space, except under unusual circumstances (where changes due to growth patterns or additional extractions make replacement necessary).
20. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.
21. Repair of a damaged space maintainer is not covered.
22. Recementation of space maintainers is payable once within 12 months.
23. Space maintainers are not covered for patients 14 years and older.
24. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by contractor or chargeable to the patient by a participating network dentist.

Restorative Services

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D2140	Amalgam—one surface, primary or permanent
D2150	Amalgam—two surfaces, primary or permanent
D2160	Amalgam—three surfaces, primary or permanent
D2161	Amalgam—four or more surfaces, primary or permanent
D2330	Resin-based composite—one surface, anterior
D2331	Resin-based composite—two surfaces, anterior

D2332	Resin-based composite—three surfaces, anterior
D2335	Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior
D2910	Recement inlay, onlay, or partial coverage restoration
D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D2930	Prefabricated stainless steel crown—primary tooth
D2931	Prefabricated stainless steel crown—permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2951	Pin retention - per tooth, in addition to restoration
D2970	R Temporary crown (fractured tooth)

The following policies apply to restorative services:

1. Coverage is for basic restorative services of amalgam fillings and anterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.
2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.
3. Replacement of a restoration by the same dentist or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.
4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents, gingivectomy, infection control and expenses for compliance with OSHA regulations, etc. is not payable.
5. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension, are not covered.
6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review.
7. Posterior restorations not involving the occlusal surface are paid as one surface restorations, subject to review.
8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.
9. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.
10. Pin retention is payable once per restoration to the same dentist or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.
11. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 24 months is not covered.
12. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.
13. Pin retention and buildups on primary teeth are covered in the fee for the restoration.
14. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.
15. Recementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.
16. After six months from the initial cementation date, recementation of crowns is payable once within 12 months.

17. Payment for a temporary crown (D2970) will be made for a damaged tooth as an immediate protective device once per tooth per lifetime unless justified by treating dentist, by report.
18. Composite resin restorations on posterior teeth are not covered procedures and payment is the patient's responsibility.

Endodontic Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D3120	Pulp cap—indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)
D3310	Root canal therapy—anterior (excluding final restoration)
D3320	Root canal therapy—bicuspid (excluding final restoration)
D3330	Root canal therapy—molar (excluding final restoration)
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3346	Retreatment of previous root canal therapy—anterior
D3347	Retreatment of previous root canal therapy—bicuspid
D3348	Retreatment of previous root canal therapy—molar
D3351	Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery—anterior
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)
D3425	Apicoectomy/periradicular surgery—molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling—per root
D3450	Root amputation—per root
D3920	Hemisection (including any root removal), not including root canal therapy

The following policies apply to endodontic services:

1. An indirect pulp cap is payable only by report with radiographs documenting a near exposure of the pulp and when the final restoration is not completed for at least 60 days. An indirect pulp cap is included in the fee for the restoration when the restoration is placed in less than 60 days.
2. An indirect pulp cap is only payable once per tooth by the same dentist.
3. A direct pulp cap is included in the fee for the restoration or palliative treatment.
4. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist or group practice is to be included in the fee for the root canal therapy.
5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.

6. Endodontic procedures in conjunction with overdentures are not covered benefits.
7. The completion date for endodontic therapy is the date the tooth is sealed.
8. Retreatment of apical surgery or root canal therapy by the same dentist or group practice within 24 months is considered part of the original procedure.
9. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.
10. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a dentist not completing the endodontic therapy.
11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.
12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.
13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed with codes D3310 – D3330, D3346 – D3348, or D3351 – D3353 on the same day or within 30 days (same tooth/same provider/same office).

Periodontic Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

- | | | |
|-------|---|---|
| D4210 | R | Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant |
| D4211 | R | Gingivectomy or gingivoplasty—one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4240 | R | Gingival flap procedure, including root planing—four or more contiguous teeth or bounded teeth spaces per quadrant |
| D4241 | R | Gingival flap procedure, including root planing—one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4245 | R | Apically positioned flap |
| D4260 | R | Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bounded teeth spaces per quadrant |
| D4261 | R | Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bounded teeth spaces per quadrant |
| D4263 | R | Bone replacement graft—first site in quadrant |
| D4264 | R | Bone replacement graft—each additional site in quadrant |
| D4266 | R | Guided tissue regeneration—resorbable barrier, per site |
| D4267 | R | Guided tissue regeneration—non-resorbable barrier, per site (includes membrane removal) |
| D4270 | R | Pedicle soft tissue graft procedure |
| D4271 | R | Free soft tissue graft procedure (including donor site surgery) |
| D4273 | R | Subepithelial connective tissue graft procedures, per tooth |
| D4341 | R | Periodontal scaling and root planing—four or more teeth per quadrant |
| D4342 | R | Periodontal scaling and root planing—one to three teeth per quadrant |
| D4355 | R | Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis |
| D4910 | | Periodontal maintenance |
| D4920 | R | Unscheduled dressing change (by someone other than treating dentist) |

The following policies apply to periodontic services:

- I. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.

2. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.
3. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.
4. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.
5. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.
6. Osseous, gingival and synthetic grafts must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis.
7. Bone grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.
8. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.
9. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same dentist.
10. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planning, periodontal surgery and periodontal maintenance.
11. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.
12. An apically positioned flap is subject to documentation when performed and when not related to implants.
13. Full-mouth debridement is payable once per lifetime per patient.
14. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II or greater periodontal disease. All procedures must be completed within 90 days.
15. Bone grafts, soft tissue grafts and guided tissue regeneration are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.

Oral Surgery Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	X Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	X Removal of impacted tooth—soft tissue
D7230	X Removal of impacted tooth—partially bony
D7240	X Removal of impacted tooth—completely bony
D7250	X Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7280	Surgical access of an unerupted tooth
D7285	R Biopsy of oral tissue—hard (bone, tooth)
D7286	R Biopsy of oral tissue—soft
D7290	R Surgical repositioning of teeth
D7310	Alveoplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant
D7910	R Suture of recent small wounds—up to 5 cm
D7911	R Complicated suture—up to 5 cm
D7912	R Complicated suture—greater than 5 cm
D7971	Excision of pericoronal gingiva

The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.
2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.
3. All hospital costs and any additional fees charged by the provider arising from procedures rendered in the hospital are the patient's responsibility.
4. Surgical removal of impactions is payable according to the anatomical position.
5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.
6. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.
7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.
8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.
9. Excision of pericoronal gingiva is payable once per tooth.
10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.
11. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.
12. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.

Adjunctive General Services

The TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

Emergency Services—100% coverage

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: Yes

Applies to Maximum: Yes

D0140	Limited oral evaluation—problem focused
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Emergency Services—80% coverage

Coverage: 80%

Patient Pays: 20%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9110 Palliative (emergency) treatment of dental pain—minor procedures

The following policies apply to emergency services:

1. Limited oral evaluation—problem-focused (D0140) must involve a problem or symptom that occurred suddenly and unexpectedly and requires immediate attention (emergency). This is paid as an emergency service and payment by Delta Dental is limited to one in a 12-month period for the same dentist. A limited oral evaluation does not count as one of the two evaluations, comprehensive and/or periodic, allowed in a 12-month period. Payment for additional D0140 evaluations in a 12-month period by the same dentist are the responsibility of the patient.
2. Emergency palliative treatment is payable on a per-visit basis, once on the same date. All procedures necessary for relief of pain are included.
3. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

Drugs

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9610 R Therapeutic parenteral drug, single administration

D9612 R Therapeutic parenteral drugs, two or more administrations, different medications

D9630 R Other drugs and/or medicaments

The following policies apply to coverage of drugs and medications:

1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.
2. The fee for medicaments/solutions is part of the fee for the total procedure.
3. Reimbursement for pharmacy-filled prescriptions is not a benefit.
4. Fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.
5. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

Post-Surgical Services

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

D9930 R Treatment of complications (post-surgical), unusual circumstances

The following policy applies to post-surgical services:

- I. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

Exclusions

The following services are not benefits under the Basic TRDP:

1. Procedures not specifically listed are not payable, other than those modified by Delta Dental or those toward which an alternate benefit is provided by the program and as defined within the benefits policies.
2. Services for injuries or conditions that are covered under Worker's Compensation or Employer's Liability Laws.
3. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.
5. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
6. Those performed prior to the member's effective coverage date.
7. Those incurred after the termination date of the member's coverage unless otherwise indicated.
8. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.
9. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
10. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
11. Prescribed or applied therapeutic drugs, premedication, sedation, analgesia and general anesthesia.
12. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.
13. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.
14. Those not meeting accepted standards of dental practice.
15. Those which are for unusual procedures and techniques.
16. Plaque control programs, oral hygiene instruction, and dietary instruction.
17. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting and full-mouth rehabilitation.
18. Gold foil restorations.
19. Premedication and inhalation analgesia.

20. House calls and hospital visits.
21. Experimental procedures.
22. Telephone consultations.
23. Those performed by a provider who is compensated by a facility for similar covered services performed for members.
24. Those resulting from the patient's failure to comply with professionally prescribed treatment.
25. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.
26. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
27. Duplicate and temporary devices, appliances, and services.
28. All hospital costs and any additional fees charged by the dentist for hospital treatment.
29. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
30. Implants (materials implanted into or on bone or soft tissue), maintenance of implants or the removal of implants.
31. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
32. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.
33. Orthodontic services.
34. Prosthodontic services.
35. Cast crowns, inlays, onlays or partial crowns.
36. Treatment provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada.
37. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.
38. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.

Claims

Claims Submission

All TRDP claims are processed by Delta Dental of California. Claims are processed quickly and easily when:

- Your records are updated with current information: dental office address, tax identification number, and license information;
- Submitted with the current tax identification number (TIN);
- Submitted with the name and license number of the treating dentist;
- The retired sponsor's social security number is complete and accurate;
- The patient's full name, date of birth and mailing address (including ZIP code) are included;
- The amount paid by other dental coverage, if applicable, is indicated;
- The patient is eligible at the time of treatment according to Delta Dental's TRDP enrollment data; and
- Necessary reports or other required documentation are attached.

When to File Claims

Submit TRDP claims to Delta Dental as soon as possible after completion of the treatment. To be considered for reimbursement, the claim must be received by Delta Dental within 12 months following the month in which the services were provided. This time limitation for claims submission is specified in the TRDP contract between Delta Dental and the Department of Defense. In cases where this rule varies from your local Delta Dental member company's practice, the federal provision prevails with respect to claims for TRDP enrollees. If a claim is not submitted within the specified time limitation, Delta Dental must deny it.

Delta Dental dentists may not charge a TRDP patient for any amount that would be payable by Delta Dental if a timely claim had been submitted, unless the patient failed to tell the dentist that he or she was covered under the TRDP.

Where to File Claims

Send TRDP claims electronically to Delta Dental using the Federal Services payer ID number via the Dental Office Toolkit® (see the "Dental Office Toolkit®" section in this handbook), through your practice management vendor or your claims clearinghouse.

Full-sized standard claim forms should be mailed to:

Delta Dental of California
Federal Services
PO Box 537007
Sacramento, CA 95853-7007

Claims Requiring Documentation

For the determination of benefits, claims for dental services listed with an "R" require documentation of the circumstances involved with the treatment provided. Examples of documentation include clinical reports, periodontal charts and/or photographs.

Claims Requiring X-rays

Please do not submit radiographs unless an “X” is indicated next to the procedure listed in this handbook. Delta Dental may request a radiograph for procedures that are not indicated by an “X” if necessary to determine benefits. In either case, submit duplicate x-rays whenever possible, as the originals could be lost in the mail. Duplicate x-rays will not be returned to the dental office.

Radiographs can also be received electronically for the TRDP through the *FastAttach*[™] system from National Electronic Attachment, Inc. (NEA). NEA is an electronic repository that allows dentists to transmit attachments via the Internet to NEA to be reviewed by payers. Information on the *FastAttach*[™] system is available at www.nea-fast.com.

Requests for Additional Information

If Delta Dental determines that more information is needed to process a submitted claim, we may send you an Information Request (IR) for clarification and/or additional information. You can minimize processing delays by responding immediately with the required information attached to a copy of the IR. If Delta Dental does not receive your response to the IR within 30 days, the claim is denied.

Predetermination Requests

Predetermination requests are not required by the TRDP but are highly recommended for the more complicated and expensive procedures offered under the Enhanced TRDP, such as cast crowns, bridges, dental implant services, and dentures. If you are uncertain whether or not a particular service under one of these categories is covered under the Enhanced TRDP, or if you want an estimate of the amount the Enhanced Program pays for this type of service, you may submit a predetermination request. A predetermination request outlines your proposed treatment plan on a claim form and results in Delta Dental’s non-binding, written estimate of how much the Enhanced TRDP covers for a particular service.

Complete the predetermination request on a claim form and include the same information required to process a claim, such as specific procedure code(s), treatment plan, and reports or x-rays, if needed. Leave the dates of service blank because the treatment is only proposed and not yet completed. You may submit both a predetermination request for planned treatment and a claim for completed treatment on the same claim form; in this case, however, make certain to leave the dates of service blank for those items for which you are requesting a predetermination. When the claim form is submitted, Delta Dental will process any undated claim line as predetermination requests.

Delta Dental will process the predetermination request and issue a pre-treatment estimate, called a Predetermination Notice, to the participating TRDP network dentist. A copy of the notice will be sent to the patient. When the treatment is complete, you should fill in the date(s) of service on the Predetermination Notice, sign the notice and return it to Delta Dental at the address listed in the “Where to File Claims” section of this handbook. Upon receipt of the completed and signed Predetermination Notice, Delta Dental will make a final determination of program eligibility, maximums, benefits, limitations and allowable fees.

Predeterminations are valid up to 12 months from the date of issue. After 12 months, predeterminations are deleted from our files. If you submit predetermined services on a new claim form rather than on the Predetermination Notice, Delta Dental will treat the claim as new and will require x-rays and/or other documentation as necessary to process it.

Claims Payment

For any single procedure that is a TRDP covered service (except orthodontic treatment as described previously), Delta Dental makes payment upon completion of the procedure. Payment is applied to the deductible and maximum based on the date of service, regardless of when the claim is submitted.

Delta Dental dentists—including dentists who participate in the networks that support the TRDP—receive their claim payments directly from Delta Dental. Delta Dental dentists may collect only the TRDP patient's portion of the charges.

Delta Dental sends a DeltaUSA network dentist one check for all of his or her claims processed during a single payment cycle. One or more Claim Payment Statements that contain detailed claim and summary adjustment information are included along with the check sent to the dentist. During the same payment cycle, Delta Dental also generates a notification to the TRDP patient in the form of an Explanation of Benefits (EOB).

Note: Delta Dental may automatically recoup overpayment of a claim from future payment checks that may or may not be for claims submitted on behalf of the same patient for whom the overpayment was originally made.

Participating TRDP network dentists have agreed that the fees charged for covered services provided to enrollees under the Basic and Enhanced TRDP will not exceed the lesser of the submitted fees or:

- The most current schedule of allowed fees to which you have agreed under the terms of your participating dentist network agreement as a Delta Dental PPO/DPO dentist with your local Delta Dental member company and applicable fee schedule.
- The most current schedule of allowed fees to which you have agreed as a participating TRDP network dentist who does not belong to the Delta Dental PPO/DPO network.

Dentists who are not participating TRDP network dentists but who do participate with their local Delta Dental member companies as Delta Dental Premier® dentists also receive payment directly from Delta Dental. Payment for these dentists is based on the TRDP non-participating dentist fee table. Delta Dental Premier® dentists are allowed to bill their TRDP patients for any balance up to their approved fee on file with their local Delta Dental member company.

Waiver of Copayment

The TRDP covers dental services at various percentages. The remaining percentage of the allowed fee is the patient copayment. Calculation of the copayment must be based on the allowed fee for the TRDP, not the dentist's regular charges.

Participating TRDP network dentists providing care under the TRDP must make reasonable efforts to collect the full amount of the patient's copayment. Offering to accept Delta Dental's payment as payment in full or routinely failing to collect the full patient copayment (waiver of copayment) is considered a form of dental program fraud known as "overbilling."

Overbilling has been identified by the American Dental Association as unethical conduct and is specifically prohibited by law in many states. Delta Dental investigates all suspected cases of overbilling, and violations may result in the termination of the dentist's participating network agreement.

Coordination of Benefits

Your TRDP patient may have other dental coverage in addition to the TRDP. Coordination of benefits (COB) is the process carriers follow to ensure that the combined benefits from all group programs under which the patient is covered do not exceed 100 percent of the allowed fee. To take advantage of all of your TRDP patient's benefits, you need to:

- Determine which carrier is primary.
- Submit the claim to the primary carrier indicating full information about the secondary carrier.
- Send a claim to the secondary carrier, indicating the amount the primary carrier paid, even if the primary carrier paid zero.

In cases where there is other dental coverage, the following COB rules determine coverage and payment:

- If the primary TRDP enrollee (retiree or unremarried surviving spouse) has another dental plan that is principally a dental program, the plan that was effective first would be the first to pay.
- Delta Dental will generally make the first payment if the other coverage is not principally a dental program.
- If the spouse has his or her own dental plan that is principally a dental program, claims for the spouse's dental treatment should be filed with that plan first.
- Private insurance carriers are primary when the patient is also covered under a state-funded program such as Medicaid.
- The claim should be filed first with the plan that pays first. Information about the first plan's payment is used by the secondary plan to determine its payment. If Delta Dental pays first, the other plan will determine how much it will pay after Delta Dental's payment has been made. If the other plan pays first, Delta Dental will determine how much it will pay after the other plan has paid.
- The combined payments made by Delta Dental and the other coverage carrier should not exceed your approved charges.
- If a patient is covered by the TRDP and has other dental insurance, the participating dentist cannot bill for the difference (if any) between the submitted and the approved charges of the TRDP.

Birthday Rule

The "birthday rule" determines the primary carrier (the first carrier to pay) for dependent children who are covered under two different plans. This rule defines the primary insurance carrier as the carrier of the parent whose birthday (month and day only) occurs earlier in the calendar year. For example, if the dependent child's mother was born on May 1 and the father was born on May 5, the mother's plan is the primary carrier and the first to pay. The parents' years of birth do not matter—only the months and days of birth are considered under the birthday rule.

As a Department of Defense contractor and administrator of the TRDP, Delta Dental is required by law to adhere to this "birthday rule" as defined by the National Association of Insurance Commissioners.

Custody Cases

In cases where a dependent child of divorced parents has dual coverage, the following rules apply:

- If one parent has been awarded custody, then the custodial parent's coverage pays first and the non-custodial parent's coverage pays second.
- If the parent with custody remarries, the custodial parent's coverage pays first and the stepparent's coverage pays second.
- If the custodial parent does not have other coverage, but the child's stepparent does, then the stepparent's coverage pays first and the non-custodial parent's coverage, if applicable, pays second.
- If there is joint custody and there is no specific court decree that establishes responsibility for one parent over the other, the "birthday rule" applies.
- In special cases, a court may determine that other applicable could apply.

Sometimes it is not possible to determine which coverage pays first, even after checking these rules. In this case, the dental plan that has covered the person longer usually pays first.

Dental Office Toolkit®

Overview of the Dental Office Toolkit®

The Dental Office Toolkit® (DOT) is designed to increase the efficiency of your administrative processes when providing care for TRDP patients. It is a cost-effective, online tool that allows you to:

- **Check eligibility information.**
You can use the DOT to check the eligibility of your TRDP patients.
- **Retrieve benefit information.**
You can access specific benefit information such as coverage levels and copayments for eligible TRDP patients.
- **Check claims status.**
You can check on the status of your TRDP claims and predeterminations submitted through the DOT without having to make a phone call.
- **Submit claims and predeterminations.**
You can submit your TRDP claims and predeterminations online, eliminating the necessity for paper claims and/or the cost per claim that most clearinghouses charge for electronic claims submission. If you choose to sign up for direct deposit of your claims payments, you also receive Predetermination Notices online, eliminating most of the time between your submission and our response.
- **Edit and delete submitted claims.**
You can make same-day changes to your claims or delete claims even after you have submitted them for processing--quickly, efficiently, and all online.
- **Receive and review electronic payments.**
You can accept payments electronically and have them deposited directly into your bank account. With the DOT, you receive your direct deposit payment notification online.

There are no fees to submit claims or to use any of the additional features of this service. To start using the DOT, visit the TRDP web site at www.trdp.org and follow the instructions for registering. Additional information about the DOT, including a list of frequently asked questions, is available on the web site.

Security

The transmission of personal and/or private information over the Internet is an important concern for everyone. Federal regulations such as the Health Insurance Portability and Accountability Act (HIPAA) mandate the protection of individually identifiable patient information from public access. Your privacy, as well as that of your patients, is a key element of the DOT.

Password Protection

To use the DOT, dentists are required to register and create a password. When you first register, you participate in a process that creates a password and provides us with the information to authenticate you in the future. As part of this process, you are asked to select and answer a personal “secret” question that allows us to identify you in the future when making a password change. As an additional security measure, the Toolkit prompts offices to create a new password every 60 days.

Encrypted Transmissions

As registration and claims information “travels” between your computer system and the DOT, it is secured using a 128-bit SSL (Secured Socket Layers) encryption program. With encryption, almost any possibility that personal information could be intercepted prior to its secure storage at Delta Dental is eliminated. While it is impossible to guarantee absolute security, Delta Dental makes efforts that are above and beyond industry standards and that surpass HIPAA requirements in order to protect your information in all of our operating systems.

Physical Protection

Our computer system is equipped with a highly sophisticated security program to make our claims processing system as impenetrable as possible.

With this level of security, you can be assured that the entire electronic submission process through the DOT is secure—starting from your computer, to the network the claims travels across, to the system at Delta Dental, where it is processed.

Direct Deposit

You can use the DOT without signing up for electronic funds transfer (EFT). However, by signing up for EFT, it is possible for you to have your TRDP claims payments deposited directly into your bank account, usually within a few days of claims submission.

With EFT, you can:

- Receive electronic payment.
- View claims payment information posted to your Activity Log on the DOT.
- Receive claim payment remittance advice and check statements, claim payment statements and predeterminations, all online.

The advantages of direct deposit through EFT include:

- Fast payment—usually within 48 hours of claims submission.
- Efficiency—no mail to sort or checks to deposit.
- Safety—less chance of lost or stolen checks.

Any participating dentist registered with the DOT can use the direct deposit feature. To sign up, follow the directions provided in the “Direct Deposit” area of the DOT.

Glossary

Allowable Charge (Amount)

The maximum dollar amount on which benefit payment is based for each dental procedure.

Assignment of Benefits

This term refers to the authorization that a primary enrollee/patient gives Delta Dental, by signing the appropriate section on the claim form, to send payment for any TRDP covered services directly to the non-Delta Dental treating dentist.

Benefit

Dental services/procedures received by an enrollee for which all or part of the cost is paid under the TRDP.

Benefit Year

The 12-month period to which each enrollee's deductibles and maximums are applied. The TRDP benefit year begins on October 1 and runs through September 30 of each year.

Birthday Rule

The rule defined by the National Association of Insurance Commissioners that states that when a child is covered under both parents' dental plans, the plan of the parent whose birthday (month and day only) falls earlier in the calendar year is billed first. In cases of divorced or separated parents other factors must be considered.

By Report (R)

A narrative description used to report a service that requires additional information (usually in the form of a written explanation from the dentist) in order to be processed and/or considered for payment. A dental consultant evaluates these narratives. Procedures requiring a report are indicated in the dentist handbook with an "R" beside the procedure code.

Claim

A request for payment under a dental benefit plan; listing services rendered, the dates of services, and itemization of costs. Includes a statement signed by the enrollee and treating dentist that services have been rendered. The completed form serves as the basis for payment of benefits.

Code on Dental Procedures and Nomenclature

A coding structure developed by the American Dental Association (ADA) to achieve uniformity, consistency and specificity throughout the dental industry in accurately reporting dental treatment. The Code has been designated as the national standard for reporting dental services by the federal government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is currently recognized by dental insurance companies nationwide. Coding and nomenclature in this handbook follow the Current Dental Terminology (CDT) and are the copyright of the ADA.

Coordination of Benefits (COB)

A method of integrating benefits payable for the same patient under more than one plan. Benefits from all sources cannot exceed 100 percent of the total charges.

Copayment

The enrollee's portion of the allowed fee for a covered procedure.

Covered Procedure/Service

A dental procedure or service provided and/or received in accordance with the policies of the TRDP.

Date of Service

The date a dental service was completed. This is the date to be indicated on the claim form when it is submitted for payment.

Deductible

The dollar amount that must be paid by the patient towards some covered services before the TRDP payment is applied to those services.

Enrollee

An individual covered by a benefit plan.

Exclusions

Dental services and/or procedures not covered under the TRDP.

Fee Schedule

A list of the charges agreed to by a dentist and the dental insurance company for specific dental services.

Limitations

Restrictive conditions stated in a dental benefit contract, such as age, length of time covered, and waiting periods, which affect an individual's or group's coverage. The contract may also exclude certain benefits or services, or it may limit the extent or conditions under which certain services are provided.

Maximum Allowable Benefit

The total dollar amount per enrollee that Delta Dental pays during a specific period of time for covered services as specified in the TRDP's contract provisions.

Overbilling/Waiver of Copayment

According to the American Dental Association Principles of Ethics and Code of Professional Conduct, a dentist who offers to waive collection of a patient's copayment as required by the patient's dental plan and to accept the plan's "covered" percentage as payment in full is engaged in the practice of overbilling. This practice is considered deceptive, misleading and thereby unethical by the ADA because it appears that the dentist's charge to the patient for the services rendered is higher than it actually is. Overbilling can lead to higher costs for dental care and limit access to affordable dental coverage under such programs as the TRDP.

Participating TRDP Network Dentist

A licensed dentist who "participates" in the TRDP by agreeing to accept the program allowable fees as the full fee for covered treatment, complete and submit claims paperwork on behalf of the TRDP patient, and receive payment directly from Delta Dental. In the TRDP, this includes Delta Dental Legion and Delta Dental PPO/DPO network dentists.

Predetermination

A non-binding, written estimate by Delta Dental of how much the TRDP covers for a particular service. Predetermination requests from dentists are suggested for the more complicated and expensive treatments.

Reimbursement

Payment made by a third party to a beneficiary (enrollee) or to a dentist on behalf of the beneficiary (enrollee), toward expenses incurred for services covered by the contractual arrangement.

TRDP Contract

The written agreement between the U.S. Department of Defense and Delta Dental of California to administer a program of dental benefits established by Congress for Uniformed Services retirees and their family members. In addition to the laws and regulations governing the TRDP, this contract forms the terms and conditions of the benefits provided under the Enhanced TRDP.

Waiting Period

The 12-month period of time of continuous enrollment that an enrollee in the TRDP must complete before certain dental procedures become payable benefits.



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TRDP Newsletters