For retired Uniformed Services members and their families
TRICARE Retiree Dental Program (TRDP) Contact Information and Resources

About Your Groups

• Basic TRICARE Retiree Dental Program — Group Number 4600
• Enhanced TRICARE Retiree Dental Program — Group Number 4601 (4602 for overseas)

TRDP Online

• Find a TRDP network dentist
• View benefits details, check claim status
• Send questions electronically
• Submit overseas claims
• Download forms, view TRDP benefits booklet

Beneficiary Web Enrollment (BWE) Portal

• Easy online enrollment
• Disenrollment requests
• Add/remove family members
• View premium rates
• Request TRDP enrollment card

TRDP by Mail

General & Billing Inquiries:
Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007

TRDP by Phone

Interactive Voice Response (IVR):
888-838-8737 (365/24/7 automated)

Customer Service (Enrolled Members Only):
Mon – Fri (excluding holidays), 8:00 a.m. – 8:00 p.m. EST
888-838-8737
866-847-1264 (TTY/TDD)
AT&T USA Direct Access Number* + 866-721-8737 (international)
*For assistance with international dialing instructions, visit www.usa.att.com/traveler/index.jsp

Customer Service (Prospective Enrollees Only):†
Wed – Fri (excluding holidays), 1:00 p.m. – 4:00 p.m. PT (voicemail available non-hours)
855-827-6436
868-847-1264 (TTY/TDD)
AT&T USA Direct Access Number * + 866-721-8737 (international)
*For assistance with international dialing instructions, visit www.usa.att.com/traveler/index.jsp
† Assistance with enrollment-related questions only. Phone enrollments are not available.

TRDP Domestic/Overseas Claims Submission

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007
United States of America
Did you know that as a TRICARE Retiree Dental Program (TRDP) enrollee, you can decrease your cost shares for dental care by an average of 22% just by seeing a TRDP network dentist?

As their way of demonstrating how much they value your service to our country, dentists in the TRDP network have an agreement with Delta Dental to accept lower than usual fees for providing the same high-quality, comprehensive dental care to TRDP enrollees. Lower fees result in lower cost shares—and therefore additional savings—for you. And because TRDP network dentists accept lower fees, you’ll have more of your annual maximum to use for additional dental care.

Just how much (in real dollars) can you save by seeing a TRDP network dentist for your care? Typically, for routine services like exams, x-rays and cleanings, your average cost-share savings by using a network dentist would be 100%, as shown in the example below. Of course, actual individual savings for procedures covered under the TRDP will vary depending on your location, deductible/annual maximum amounts remaining, types of procedures and associated benefit coverage levels, and other factors.

<table>
<thead>
<tr>
<th>Type of Procedure (Description/CDT Code)</th>
<th>Dentist Submitted Fee</th>
<th>TRDP Benefit Coverage Level</th>
<th>Enrollee Cost Share (TRDP Network Dentist)</th>
<th>Enrollee Cost Share (Non-TRDP Network Dentist)</th>
<th>Enrollee Network Savings</th>
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</thead>
<tbody>
<tr>
<td>Periodic Exam (D0120)</td>
<td>$65</td>
<td>100%</td>
<td>$0</td>
<td>$15</td>
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</tr>
<tr>
<td>Bitewing X-rays (D0274)</td>
<td>$85</td>
<td>100%</td>
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<td>$20</td>
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<tr>
<td>Adult Prophylaxis (D1110)</td>
<td>$124</td>
<td>100%</td>
<td>$0</td>
<td>$29</td>
<td>$29</td>
</tr>
</tbody>
</table>

Participating TRDP network dentists provide other value-added services that help decrease your out-of-pocket expenses for dental care. For instance, network dentists will charge you only the applicable estimated cost share at the time of service, and they have agreed to accept the program allowed amount as the maximum billing fee for covered services.

Seeing a TRDP network dentist can save you hundreds of dollars on dental care throughout your TRDP enrollment. If you want to save the most money, be sure that your dentist is a participating TRDP network dentist. Visit trdp.org for a list of TRDP network dentists in your area.
Now that you have enrolled in the TRICARE Retiree Dental Program (TRDP), you have the benefit of many convenient self-service tools available to help you manage your program benefits—all within reach of your computer. Visit the TRDP’s dedicated, customer-friendly website at trdp.org to take advantage of such easy-to-use features as:

- **The Enrollee/Consumer Toolkit®**
  As a TRDP enrollee, you can sign on to the online enrollee Consumer Toolkit® using the subscriber’s identification number (social security number) and your date of birth to verify your eligibility, get up-to-date benefits information, find out the amount of your maximum and deductible that you have used to-date, review your processed claims and reimbursements, view your current account balance and premium payment history, print an account statement and even sign up for paperless dental benefit statements.

- **Find a Dentist**
  The online “Find a Dentist” function allows you to search for a TRDP network dentist in your area. Remember: Seeing a TRDP network dentist whenever possible assures you of maximum cost savings, added program value, and the very best in dental care. If there’s no computer nearby, no problem: You can connect directly to our mobile-enabled TRDP dentist directory at trdp.org using your smartphone or tablet!

- **Online Inquiry**
  The online Customer Service Inquiry Form allows you to contact Delta Dental electronically during a time that is convenient for you, and receive prompt responses to your specific questions about the TRDP.

- **Viewable/Printable Program Materials**
  Download and print a claim form, view this entire benefits booklet, and find useful links to important government information.

- **Email Signups**
  Sign up to receive notice about the latest program news and updates, oral health articles and more by email.

- **Paperless Explanation of Benefits Statements**
  The ability to sign up for paperless Explanation of Benefits (EOB) statements makes it even easier for you to manage your own TRDP benefits. Instead of waiting for a paper copy of your EOB to arrive in the mail, you will get an email notification from us whenever a claim is processed; then all you have to do is click on the link in the email and view your EOB immediately, online. Log on to the Consumer Toolkit® and sign up to “Go Paperless” so that you can get your processed claims information right away—and help preserve the environment in the process.

- **SmileWay® Wellness Site**
  Our SmileWay Wellness program has information about oral health to help add value to your dental program. Review your oral hygiene habits, get educated about your dental health and stay informed on the latest breakthroughs in dentistry with the SmileWay Wellness site available at trdp.org.

Even if you do not have access to a computer, there is still help available to you. Call the Interactive Voice Response (IVR) telephone system at 888-838-8737, 24 hours a day, seven days a week to get self-service information using automated features such as:

- Eligibility verification, claim status, maximum used to-date, and remaining deductible amount
- A complete breakdown of TRDP covered services, including time limitations
- A list of dentists in a specific area, including specialists, that can be faxed or mailed to you
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If you have just enrolled in the TRICARE Retiree Dental Program (TRDP), here are some tips to help start you on your way toward getting the most value from your coverage.

- Read your TRDP benefits booklet. The information contained in this booklet will help you better understand what the TRDP covers and how to use the program. The benefits booklet can also be found on the website at trdp.org—and the online copy will always contain the most current, updated information about your benefits.

- Find a dentist. To save the most money on your dental costs, reduce the amount of paperwork and get quality dental care at the best value, see a participating TRDP network dentist. You can easily locate a network dentist near your home or office by using the “Find a Dentist” feature on our website at trdp.org.

- Make an appointment. It’s a good idea to make your first appointment as soon as you enroll. When you call to schedule your appointment, be sure to:
  - Let the office staff know that you have coverage through Delta Dental under the TRICARE Retiree Dental Program.
  - Tell the office if you are having any problems that may require immediate attention.
  - Give the staff your TRDP subscriber identification number, dates of birth for both the subscriber and the patient (if not the same), your relationship to the subscriber, and your program number so they can verify your benefits ahead of time. Applicable program numbers are: 4600 for Basic program enrollees and 4601 for Enhanced program 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; and 4602 for Enhanced Program enrollees in all other overseas locations.

When you arrive for your appointment, it is helpful to have the following items with you:

- Your TRDP enrollment card, issued by the Defense Manpower Data Center (DMDC). The staff may want to make a copy of your card for your file; however, please note that an ID card not necessary to obtain dental care under the TRDP.

- Completed forms. If forms were sent to you prior to the appointment, please bring them with you. If not, you may want to arrive a few minutes early to complete the necessary paperwork.

- A copy of your benefits information, printed from the online Consumer Toolkit® found on our website at trdp.org.

Let the office staff know if you have other dental coverage in addition to the TRDP. In order to coordinate benefits of both plans, the office will need the other carrier’s name and mailing address, coverage effective date, and primary enrollee’s name, date of birth and identification number.

Also, be prepared to pay your estimated cost share at the time of the appointment. When you see a TRDP network dentist, the office may request payment of your cost share in advance but in many cases will bill you once Delta Dental has made payment for the services.
Within a few weeks after the dental office has submitted a claim for your dental services, you should receive an Explanation of Benefits (EOB) statement. Be sure to:

- Review your Explanation of Benefits (EOB) statement carefully to make sure the services provided, the dates of service, the amounts submitted and paid, and your cost share amount are correct. For more information on how to read and understand your EOB, refer to the “Claims Submission and Payment” section of this booklet.

- Maintain good records of your dental treatment. The online Consumer Toolkit® lists all your EOBs and allows you to sign up for electronic delivery of your statements, allowing you a paperless way to keep track of your processed claims and payments.

Following the above tips will help you get off to a good start with the TRDP. And remember: You can control your dental costs by

- Seeing a TRDP network dentist.
- Using the self-service Consumer Toolkit and signing up for paperless EOBs.
- Knowing all your TRDP benefits, policies and exclusions.
- Scheduling regular dental checkups for yourself and your family.
- Following your dentist’s advice about your dental care
The TRICARE Retiree Dental Program (TRDP) is offered by the Department of Defense (DoD) through the Defense Health Agency (DHA). The Federal Government Programs division of Delta Dental of California, located in Sacramento, California, administers and underwrites the TRDP for the DHA under contract with the DoD.

The TRDP offers a voluntary group benefits program of comprehensive, cost-effective dental coverage for retired members of the Uniformed Services and their family members, unremarried surviving spouses and children of deceased members, and other select individuals. The Uniformed Services include the Air Force, Army, Navy, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and U.S. Public Health Service as well as their Reserve and National Guard components.

Except where noted, the information contained in this benefits booklet applies to enrollees in both the Basic TRDP (group 4600) and the Enhanced TRDP (group 4601) under the policies and regulations effective January 1, 2014. The Basic TRDP was closed to new enrollments on August 31, 2000 and remains closed; however, enrollees in the Basic TRDP may remain enrolled or may upgrade their coverage to the Enhanced TRDP at any time and waive the 12-month waiting period for major services that most new enrollees must satisfy.

Enrollees in the Enhanced TRDP who live overseas have a different group number (4602) but have worldwide access to the same scope of benefits as that of Enhanced TRDP enrollees living within the service area. All covered benefits, policies, limitations and exclusions of the Enhanced TRDP as outlined in this benefits booklet apply to overseas enrollees except where noted.

**Eligibility**

**Eligibility Requirements**

Eligibility requirements for enrollment in the TRDP are set by the federal government in the laws that established the program. Eligibility to enroll in the TRDP is verified through the Defense Enrollment Eligibility Reporting System (DEERS).

To be enrolled in the TRDP, an individual must be one of the following:

- A member of the Uniformed Services who is entitled to retirement pay, including those age 65 or over.
- A member of the National Guard/Reserves who, regardless of age, has transferred to Retired Reserve status. This includes a retired member of the National Guard/Reserves who is entitled to retirement pay, even if under age 60, i.e., a retired member in the “gray area” who is entitled to retirement pay but does not actually begin receiving it until age 60.
- A current spouse of an enrolled retired member as described above.
- An enrolled member’s eligible child
  - Up to age 21 (including stepchildren, adopted children and court-ordered wards). Beneficiaries in this category are eligible up to the end of the month in which they turn 21.
  - Up to age 23 if enrolled in a full-time course of study at an approved institution of higher learning (proof of full-time student status may be required).
  - Older than age 23 if the child has a disabling illness or injury that occurred before his/her 21st birthday, or that occurred between ages 21 and 23 while the child was enrolled in a full-time course of study at an approved institution of higher learning.
• An unremarried surviving spouse or eligible child of a deceased member who died on retired status or who died while on active duty for a period of more than 30 days and whose eligible family members are not eligible, or are no longer eligible, for dental benefits under the active duty family member dental plan (TRICARE Dental Program).

• A Medal of Honor (MOH) recipient and eligible immediate family members, or an unremarried surviving spouse/eligible immediate family members of a deceased MOH recipient.

• A family member of a non-enrolled member who meets certain criteria. Under most circumstances, the retiree must enroll in order for a spouse or other eligible family member to enroll. However, eligibility rules implemented October 1, 2000 allow the spouse and/or eligible child of a non-enrolled member to join the TRDP with documented proof that the non-enrolled member is:
  o Eligible to receive ongoing, comprehensive dental care from the Department of Veterans Affairs; or
  o Enrolled in a dental plan that is available to the member as a result of employment separate from his/her Uniformed Service, and said dental plan is not available to his/her family members; or
  o Prevented from being able to obtain benefits under the Enhanced TRICARE Retiree Dental Program due to a current and enduring medical or dental condition.

If a retiree meets any one of these three criteria and wishes to enroll a family member without joining the TRDP, written documentation may be required to be submitted with the enrollment form, as applicable.

Overseas applicants for the TRDP must meet these eligibility requirements for enrollment and must reside permanently outside 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, or Canada.

Although the Basic TRDP is closed to new enrollments, the addition of a family member to an existing basic program enrollee's account is allowed. The family member you enroll must meet the eligibility requirements as defined above and as verified through the Defense Enrollment Eligibility Reporting System (DEERS).

For answers to many of your questions about the eligibility requirements of the program, please visit the TRDP website at trdp.org.

Individuals Who Are Not Eligible

By law, individuals who are not eligible for this program are:

• Former spouses of eligible members
• Remarried surviving spouses of deceased members
• Family members of non-enrolled retirees who do not meet one of the three special circumstances noted above.

Survivor Eligibility

An unremarried surviving spouse of a sponsor who died while serving on active duty for more than 30 consecutive days who is enrolled in the TRICARE Dental Program (TDP) Survivor Benefit will lose eligibility for the TDP once the three-year Survivor Benefit period ends. However, surviving spouses are eligible to enroll in the TRICARE Retiree Dental Program (TRDP). If a surviving spouse’s children no longer qualify for the TDP Survivor Benefit, they may also be eligible to enroll in the TRDP.
Following is a list of things surviving spouses should remember before, during and after enrolling in the TRDP.

**Before:**

- Surviving spouses should check with the Defense Enrollment Eligibility Reporting System (DEERS) to make sure their personal information is up to date. Contact DEERS online at https://www.dmdc.osd.mil/milconnect.
- TRDP enrollment is not automatic once the TDP Survivor Benefit ends. Surviving spouses should obtain a letter from the TDP contractor verifying their three-year TDP Survivor benefit period has ended and submit a copy of the letter along with their TRDP enrollment application.
- It is important to carefully review all the information in this booklet and on the website at [trdp.org](http://trdp.org), including our short program video.

**During:**

- Surviving spouses may enroll online through the TRICARE Beneficiary Web Enrollment (BWE) portal or by filling out a paper application and mailing it to Delta Dental. The website at [trdp.org](http://trdp.org) has easy-to-follow instructions for enrolling in the TRDP once the TDP Survivor Benefit ends.
- Surviving spouses who enroll within four months after their three-year TDP Survivor Benefit period ends may be able to skip the 12-month waiting period for major services such as cast crowns, onlays, bridges, partial/full dentures, dental implants and orthodontics. This waiver is not automatic, so surviving spouses should use the online inquiry form at [trdp.org](http://trdp.org) to notify Delta Dental that they have enrolled within the four-month period.
- Surviving spouses who enroll in the first month after losing their TDP Survivor Benefit should also use the online inquiry form to notify Delta Dental immediately so that we can make their coverage date retroactive and help them avoid a lapse in coverage in moving from the TDP to the TRDP.
- TRDP enrollees pay 100% of their premiums. Monthly premiums are based on the residence ZIP code and can be found using the Premium Search function at [trdp.org](http://trdp.org). A two-month premium prepayment is required at the time of enrollment; arrangements must be made to pay subsequent monthly premiums through either electronic funds transfer (EFT) or recurring credit card payment (RCCP). The EFT or recurring credit card authorization form should be completed at the time of enrollment to avoid any lapse in dental coverage. The forms are available on the website at [trdp.org](http://trdp.org).

**After:**

- To save the most on covered dental expenses, make sure you and your family see a TRDP network dentist for all your dental care needs. Visit the TRDP Dentist Directory online at [trdp.org](http://trdp.org) to find a network dentist near you.
- Sign up for the online Consumer Toolkit® to manage your TRDP account. Get 24/7 access to your benefits information and processed claims, find out how much of your maximums and deductible you have used, and sign up for paperless dental benefits statements. During the registration process, use the deceased sponsor’s social security number when prompted to enter the “Subscriber ID.”
- Refer often to your online Benefits Booklet for the most current information, and watch the program video any time you need a refresher.
- Use the tips and tools on the SmileWay® Wellness site at [trdp.org](http://trdp.org) to help you and your family stay on the right track to a healthy, beautiful smile.
- When you are unable to find an answer to your question on the website, send us an online inquiry any time for a prompt response.
Surviving spouses of deceased retirees who were already enrolled in the TRDP at the time of the retiree’s death and who wish to continue their enrollment should first check DEERS to make sure their status is updated, and then make arrangements to pay their ongoing monthly TRDP premiums through EFT or RCCP as described above. Surviving spouses of deceased retirees who were not already enrolled in TRDP are eligible to enroll at any time, and should follow the enrollment instructions above.

TRDP Service Area

TRDP Basic dental coverage is offered throughout the 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. To be eligible for reimbursement, covered services must be provided within this area, regardless of where the TRDP Basic enrollee lives. There are no overseas benefits for TRDP Basic enrollees.

Enhanced TRDP dental coverage is offered worldwide, with benefits based on primary residence. Enhanced TRDP enrollees are eligible to obtain their covered benefits within the service area described above. When traveling outside this area, Enhanced TRDP enrollees who are enrolled and living in the 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 are only eligible for emergency services overseas. (Exemption: An Enhanced TRDP enrollee’s family member who is a full-time student living overseas can receive benefits worldwide.) Enhanced TRDP enrollees are fully responsible for payment to the dentist who provided the emergency care. These enrollees will need to submit a claim form which can be downloaded at trdp.org. Delta Dental will reimburse the enrollee as applicable when the overseas emergency services claim is processed.

Enrollees in the Enhanced program who reside permanently outside the above service area may obtain the full scope of TRDP benefits anywhere in the world. If receiving care within the above service area, enrollees can receive care from a TRDP network dentist. Additional information applicable to Enhanced TRDP enrollees who reside overseas is available in this benefits booklet and on the website at trdp.org.

Selecting Your Dentist

Participating TRDP Network Dentists

The TRDP offers you a wide selection of dentists from which to choose for your dental care. An expansive nationwide* network of dentists who participate in the TRDP allows you to experience optimum cost savings while getting the highest quality of dental care and the most value from your TRDP enrollment.

Participating TRDP network dentists’ fees are established by Delta Dental. Only dentists who are members of the participating TRDP network have agreed to accept these “allowed” fees, which are typically lower than those charged by dentists who do not participate in the TRDP network.

Participating TRDP network dentists have agreed not to bill you for any difference between their billed charges and the agreed-upon fees for covered services. You are responsible only for your cost share amount as well as any applicable deductible and amount over the annual maximum benefit. Because fees charged by participating network dentists are lower, your cost shares are proportionately lower—meaning less money will come out of your pocket for your dental care. Your annual maximum amount will not be met as quickly as it would if you saw a dentist outside the TRDP network, so you will likely have additional money to apply toward other services you may need.

As well as agreeing to accept lower fees for TRDP covered services, participating network dentists have agreed to provide other services that will save you time, money and paperwork and add even further value to your enrollment.
For instance, participating network dentists will

- Submit predeterminations when requested.
- Complete and submit your TRDP claim forms to Delta Dental, free of charge.
- Accept payment directly from Delta Dental. (Delta Dental will send you an Explanation of Benefits showing the allowed fee, Delta Dental’s payment amount and your cost share.)
- Adhere to Delta Dental’s quality-of-care provisions.
- Provide x-rays, clinical information and other documentation needed for claim processing.

**Locating a Participating Network Dentist**

You can easily locate a participating TRDP network dentist in your area by searching the Dentist Directory on our website at trdp.org. The online Dentist Directory contains the names, addresses, telephone numbers and gender of all TRDP participating network dentists, as well as whether or not their dental office is accepting new patients. Each search generates a list of up to 60 randomly selected dentists, allows you to specify the distance you are willing to travel, and provides a map showing directions to the dentist’s office. You can also obtain a list of participating dentists near you by calling Delta Dental’s Interactive Voice Response System (IVR).

*TRDP participating network dentists are located in the 50 United States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. There are no participating network dentists in American Samoa, the Commonwealth of the Northern Mariana Islands, or Canada.*

**Out-of-Network Dentists**

Dentists who do not belong to the participating TRDP network are considered out-of-network dentists. If you go to an out-of-network dentist, Delta Dental will pay the same percentage for covered services as it will for a participating network dentist; however, you should be aware that the fees out-of-network dentists charge could potentially be higher than the allowed fees that participating TRDP network dentists agree to accept, and that could affect your out-of-pocket costs.

There are two categories of out-of-network dentists: Delta Dental dentists who are not part of the participating TRDP network (these include Delta Dental Premier® dentists) and dentists who do not belong to any Delta Dental network, referred to as non-Delta Dental dentists.

**Delta Dental Dentists**

Not all Delta Dental dentists participate in the TRDP dentist network. Although Delta Dental Premier® dentists may choose not to participate in the TRDP network, they will file claims for you and have agreed to follow Delta Dental’s national processing policies and the quality-of-care provisions of their Delta Dental agreement. Additionally, Delta Dental Premier® dentists will not bill you for more than your cost share and applicable deductible plus the difference up to their “approved amount.”

If you see a Delta Dental Premier® dentist, it is important to take your benefits booklet with you on your first visit. The information in this booklet will help the dentist better understand your coverage. Additionally, the following paragraph will assist the dentist in understanding that the provisions of his or her agreement with Delta Dental apply to the TRDP as well.

*The TRICARE Retiree Dental Program is a group program that provides benefits to enrolled retirees of the Uniformed Services and their family members. It is structured as a dental PPO program that includes participating network dentists who support the TRDP. When the enrollee receives treatment from a Delta Dental dentist who does not participate in the TRDP network, Delta Dental’s payment is sent directly to...*
the dentist and is based on the dentist’s local fee agreement and Delta Dental processing policies. Therefore, all of the fee provisions of the dentist’s agreement with the local Delta Dental member company apply to this program.

Non-Delta Dental Dentists

Non-Delta Dental dentists will bill you their usual fees, which in most cases will be higher than the fees allowed by the TRDP. You will be responsible for paying your cost share plus any difference between the TRDP allowed amount and the dentist’s submitted (billed) charges. A non-Delta Dental dentist may require full payment at the time service is provided. Additionally, a non-Delta Dental dentist is not required to submit your claims for you or to adhere to Delta Dental’s claims processing policies. Delta Dental will direct payment to the subscriber/patient unless payment has been authorized directly to the non-Delta Dental dentist. (This authorization is known as “assignment of benefits.” As a TRDP enrollee, it is your responsibility to ensure that the authorization section of the claim form is completed correctly to indicate whether Delta Dental’s payment for covered services should be directed to the subscriber/patient or assigned to the non-Delta Dental dentist. If you DO NOT want payment to be sent directly to the non-Delta Dental dentist, make sure you do not sign or make any other types of marks on the authorization signature line.)

Finding a Dentist Overseas

Although Delta Dental does not maintain a participating TRDP dentist network outside the area listed above, Enhanced TRDP enrollees who require emergency treatment while traveling, or Enhanced TRDP enrollees living overseas, have other options for finding a dentist overseas. Besides a referral from your local dentist or from friends or family who are living overseas, the American consulate, American embassy and even the hotel concierge in the country in which you are visiting or living may be able to help you locate a dentist.

Delta Dental’s International Dentist Referral Service

Enhanced TRDP enrollees needing emergency care overseas and those living permanently overseas may also search a list of dentists and dental clinics in foreign countries, provided through Delta Dental’s international dentist referral service. Enrollees may call the referral service toll-free within the U.S. at 888-558-2705 or call collect from outside the U.S. at 312-356-5971.

When you call the international referral service from outside the U.S., you must first dial the international dialing code country in which you are located and then the country code for the U.S. (dial “1”). Be sure to tell the assistance coordinator that Delta Dental is your dental coverage carrier, and specify the city and country in which you are looking for a dentist. Multi-lingual assistance coordinators are available 24 hours a day, 365 days a year to help you find an overseas dentist.

Note that dentists listed with the international referral service are not contracted or otherwise affiliated with Delta Dental, and assistance coordinators cannot answer specific questions about your TRDP coverage. If you have questions about your TRDP coverage or obtaining a claim form, please visit the website at trdp.org or call our Customer Service department. You may also contact us using the online Customer Service Inquiry Form available at trdp.org.
Terms of Enrollment

Enrollment Commitment

Enrollees in the Enhanced TRDP must commit to remain enrolled in the enhanced program for an initial 12-month period. There are no provisions in the federal regulations for voluntary disenrollment during the initial 12-month enrollment period except as outlined under “TRDP Voluntary Termination Criteria” below. If a family member is added to an Enhanced TRDP enrollee’s account after the subscriber’s initial date of enrollment, both the subscriber and the added family member must complete 12 months of enrollment starting from the added family member’s coverage effective date before either is allowed to voluntarily terminate enrollment.

Enrollment in the Basic TRDP is no longer allowed; however, eligible family members may be enrolled under a subscriber’s current basic program account. All enrollees in the Basic TRDP have completed their enrollment commitment unless they have added a family member to their account. If an eligible family member has been added, both the subscriber and the added family member must complete 12 months of enrollment starting from the added family member’s coverage effective date before either is allowed to voluntarily terminate enrollment.

Enrollment Grace Period

For enrollees in the Enhanced TRDP, there is a grace period of 30 days from the subscriber’s coverage effective date during which you may disenroll without any further enrollment obligation, provided Delta Dental has not processed a claim for TRDP dental services used by the subscriber or any enrolled family member during that time period. If you do not exercise your option to disenroll within the 30-day grace period, you must remain enrolled in the program for the duration of the 12-month period with only limited opportunity for voluntary disenrollment during this time. For more on the TRDP enrollment grace period, see “TRDP Voluntary Termination Criteria.”

Coverage Effective Date

Coverage for an Enhanced TRDP enrollee will start on the first day of the month after Delta Dental has received complete enrollment information and the correct premium prepayment amount. You can verify your TRDP eligibility and coverage effective date by logging on to the Consumer Toolkit® available on the TRDP website at trdp.org.

Coverage for a family member who is added to a Basic TRDP enrollee’s existing account will start on the first day of the month after complete enrollment information and the correct premium prepayment amount have been received. You may use the Consumer Toolkit® on the website at trdp.org to check the status of your eligibility and TRDP coverage effective date.

Enrollment Lockout

Enhanced TRDP enrollees who fail to complete their initial enrollment commitment are subject to a 12-month lockout period before they are eligible to re-enroll. Enrollees who disenroll from the Enhanced TRDP after completing the initial 12-month enrollment obligation may re-enroll at any time but will be subject to the same 12-month enrollment commitment and waiting period as a new enrollee.

Enrollment Continuation and Termination

After you have satisfied your enrollment commitment, your enrollment in the TRDP continues automatically on a month-to-month basis. You may request to disenroll at any time during your month-to-month enrollment period. If you elect to terminate your enrollment in the TRDP at the end of your or your family member’s initial 12-month enrollment commitment, Delta Dental must receive notification of your request to disenroll no less than 30 days prior to the first day of the thirteenth month.
If you request to terminate your enrollment in the TRDP at any time during your month-to-month enrollment period, any enrolled family members must also disenroll. To request disenrollment during your month-to-month enrollment period, please use one of the following options:

• Electronically (preferred): Log on to the Defense Manpower Data Center’s (DMDC) Beneficiary Web Enrollment (BWE) website at dmdc.osd.mil/appj/bwe.

• By mail: Send your written request to Delta Dental of California, Federal Government Programs, PO Box 537007, Sacramento, CA 95853-7007.

• By telephone: Call us toll-free at 888-838-8737 (TDD/TTY 800-735-2922). International customers can call us toll-free at (USADirect Access Number) + 866-721-8737.

An Enhanced TRDP enrollee who terminates enrollment after satisfying his/her initial 12-month enrollment commitment may re-enroll at any time. However, when you re-enroll, you will begin a new 12-month enrollment commitment, and you must satisfy the same waiting period for certain benefits as a new enrollee.

You may remain enrolled in the Basic or Enhanced TRDP even if you elect to terminate your family member’s enrollment at the end of the 12-month enrollment commitment. If you remain enrolled in the basic program after terminating a family member’s enrollment, you may re-enroll the eligible family member in the basic program. You or any eligible family members cannot re-enroll in the Basic TRDP once you have disenrolled; however, you may enroll in the Enhanced TRDP at any time. When you enroll in the Enhanced TRDP, you will begin a new 12-month enrollment commitment, and you must satisfy the same waiting period for certain after disenrolling from the Basic TRDP, benefits as a new enrollee.

**TRDP Voluntary Termination Criteria**

When a subscriber in the TRDP adds a family member to his or her account, both the subscriber and the added family member incur a new 12-month enrollment obligation. A request to voluntarily terminate enrollment before the subscriber or any added family member(s) has satisfied the 12-month enrollment commitment must meet the following criteria:

• **Enrollment Grace Period**

  If the initial request for disenrollment of an Enhanced TRDP enrollee or enrolled/added family member is made within 30 calendar days following the enrollment effective date and there has been no use of TRDP benefits under the enrollment, then the request is allowed. Any use of TRDP benefits by either the subscriber or enrolled/added family member during this 30-day enrollment grace period constitutes acceptance by the enrollee of the enrollment and the 12-month enrollment commitment. In this case, a request for voluntary termination of enrollment is not honored and premiums are not refunded. (See “Terms of Enrollment” section above).

  If the initial request for disenrollment of a family member added to a Basic TRDP enrollee’s existing account is received within 30 calendar days following the added family member’s coverage effective date and there has been no use of TRDP benefits under the enrollment, then the request is allowed. Any use of TRDP benefits by the added family member during this 30-day enrollment grace period constitutes acceptance by the subscriber of the enrollment and the enrollment commitment. In this case, a request for voluntary termination of enrollment is not honored and premiums are not refunded.

• **Extenuating Circumstances**

  Under limited circumstances, Delta Dental will consider requests for disenrollment for TRDP enrollees and/or enrolled family members who have been enrolled in the program beyond the 30-day enrollment grace period but who have not completed their 12-month enrollment commitment. Requests for early voluntary termination must include written, factual documentation that independently verifies that one of the following extenuating circumstances has occurred during the enrollment period. In general, the circumstances must have been unforeseen and be long-term, and must have originated after the effective date of TRDP coverage. Such circumstances include:
The enrollee is prevented by a serious medical or dental condition from being able to utilize TRDP benefits.

- The enrollee would suffer severe financial hardship by continuing TRDP enrollment.
- The enrollee is recalled to active duty.

To request voluntary termination of your enrollment during your 30-day grace period or due to extenuating circumstances, you must submit your request in writing to Delta Dental at the address listed for “General Inquiries” in the “Contact Information and Resources” section at the beginning of this booklet. For termination for extenuating circumstances, it is important that you include relevant documentation explaining the circumstances. If you have questions about the documentation required, you may use the convenient online Customer Service Inquiry Form available on our website at trdp.org, or call our Customer Service department.

The adult child of a deceased TRDP enrollee should contact DEERS at 800-538-9552 to report the enrollee’s death and request that the deceased’s records be updated. Note that DEERS may require a death certificate to process the request. After updating the information with DEERS, the adult child should contact Delta Dental to discontinue the deceased’s TRDP coverage.

Enrollment Inquiries

Use the convenient online Consumer Toolkit®, accessible through the TRDP website at trdp.org, to verify the status of your enrollment. You can find answers to many of your enrollment questions on the website; for a more detailed response to your specific inquiry, use the convenient online Customer Service Inquiry Form available at trdp.org.

Keeping Enrollment Records Current

Because Delta Dental verifies member eligibility through DEERS, it is important that DEERS contains up-to-date information on each family member to avoid unnecessary processing delays. You may verify your DEERS information by contacting the nearest Uniformed Services personnel office (where ID cards are issued). Family members age 18 and older may update their own contact information. Only subscribers or those appointed power of attorney can enroll themselves or add or delete a family member (unless they are the unremarried surviving spouse of a deceased subscriber or the deceased subscriber’s surviving dependent child who is responsible for his/her own dental care). You may update your existing enrollment record through DEERS in one of the following ways:

- Online at https://www.dmdc.osd.mil/milconnect. This method is the quickest and easiest way to update your address and contact information.

- In person at a Uniformed Services identification (ID) card-issuing facility. To locate the nearest facility, visit www.dmdc.osd.mil/rsl. Please call ahead for hours of operation and for detailed instructions.

- Call the Defense Manpower Data Center Support Office at 800-538-9552. Hours of operation are Monday through Friday, 5:00 a.m.-5:00 p.m. (PT), except on federal holidays.

- Fax changes to DEERS at 831-655-8317. Faxed documents must include the subscriber’s identification number.

- Mail changes to: Defense Manpower Data Center Support Office, 400 Gigling Road, Seaside, CA 93955-6771.
Premium Payments

Premium Rates

Premium rates for the TRDP are based on the program in which you are enrolled (Basic or Enhanced TRDP) and the ZIP code in which the subscriber (or unremarried surviving spouse and/or children) resides. In addition, monthly premiums are based on three different enrollment options: single-person enrollment, two-person enrollment, and a family enrollment of three or more persons.

Annual premium rates are in effect from January 1 through December 31 and are subject to yearly adjustment. If you move, change your enrollment option, or upgrade your enrollment from the Basic TRDP to the Enhanced TRDP, your monthly premium rate will be adjusted accordingly. Department of Defense-directed implementation of program changes could also result in further premium rate adjustments.

Enhanced TRDP enrollees can use the premium search function at trdp.org to determine the exact premium rate for your region. Basic TRDP enrollees who would like information concerning the premium rate for their region can call Delta Dental’s Customer Service department.

Premium Payment Allotments

Monthly premiums for the TRDP will be collected by the Defense Finance and Accounting Service or by the Coast Guard, National Oceanic and Atmospheric Administration or U.S. Public Health Service finance centers through a retirement pay allotment as directed by federal law. The allotment is established automatically with the appropriate finance center upon enrollment. An individual’s enrollment in the TRDP will not be interrupted or adversely affected due to problems with premium deduction from retirement pay.

Enrollees whose retirement pay allotments cannot be established or whose retirement pay allotments have ceased after having been started must pay their premiums as described below.

Premium Payments by EFT/RCCP

In cases where the appropriate finance center determined that retirement pay is not available or is insufficient to allow the allotment, enrollees are required to pay their monthly premiums by electronic funds transfer (EFT) or, if an EFT cannot be established, by a monthly recurring credit card payment (RCCP). Surviving spouses of deceased active duty members who enroll in the TRDP as well as surviving spouses of deceased retirees who either wish to retain their enrollment in the TRDP after the sponsor is deceased or who are enrolling in the TRDP for the first time must also make arrangements to pay their monthly premiums by EFT or RCCP.

Premium payment transactions through EFT/RCCP that are not honored by the enrollee’s financial institution/credit card company are considered past due. Enrollees whose premium payments become past due may have their TRDP coverage terminated by Delta Dental when premium payment accounts are not brought current. Dental claims will not be paid for time periods during which premiums remain past due. Enrollees in the Basic TRDP whose coverage has been terminated for non-payment of premiums are not eligible for re-enrollment in the basic program. Enrollees in the Enhanced TRDP whose coverage has been terminated for non-payment of premiums prior to completion of their initial enrollment obligation will not be eligible for re-enrollment for 12 months. They will also have to complete a new 12-month enrollment obligation and waiting period.

Questions Concerning Premium Payments

For questions regarding your prepayment refund, automatic retirement pay allotment, EFT/RCCP or other premium payment issues, please contact us through our online Customer Service Inquiry Form at trdp.org, or call Delta Dental’s Customer Service department. You may also view information about your premium payments on the online Consumer Toolkit®.
Claims Submission and Payment

Claims Submission

The TRDP does not require special claim forms. Participating TRDP network dentists and other Delta Dental dentists will fill out and submit your claims paperwork or transmit your claims electronically for you. Some out-of-network dentists may also provide this service upon your request; however, they may charge a fee. If you are submitting your own claim, forms are available on the TRDP website at trdp.org that you can print, fill out and submit directly to Delta Dental, as follows:

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

You may also print a claim form directly from the online Consumer Toolkit®, which is accessible at trdp.org.

Submitting Overseas Claims

Enhanced TRDP enrollees living within the 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 can obtain emergency services only when traveling outside the service area. Enhanced TRDP enrollees living permanently overseas are eligible to obtain worldwide coverage for all the services for which they are eligible. For services provided by an overseas dentist, Enhanced TRDP enrollees will need to pay in full at the time of service and should obtain a detailed receipt. To be reimbursed, enrollees must submit their claims directly to Delta Dental and include the dentist’s full name, address (including city and country), phone number and/or e-mail address, services performed and a list of the teeth treated. Delta Dental will convert the fees to U.S. dollars and make payment directly to the enrollee in U.S. dollars based on the date of service.

Enhanced TRDP enrollees can download and print a claim from the TRDP website at trdp.org. Mail your completed claims and required attachments to Delta Dental at the following address:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007
United States of America

For timely processing of your overseas claims, use the online TRDP Overseas Claim Submission form to submit your completed claims and dentist receipts electronically to Delta Dental. (Note: No signatures are needed IF you are submitting your claim electronically using the online overseas claim submission form.)

Filling out the Claim Form

For Delta Dental to process your claim quickly, it is important that the claim form is filled out completely and correctly. The following information is required on the claim form or on an attached billing statement:

- The patient’s name and birth date
- The subscriber’s name, mailing address and birth date
- The subscriber’s identification number
- The dentist’s name and license number
• The dentist’s treatment office address, city, state and ZIP code
• The date the service was completed
• A description of the service provided
• The appropriate CDT procedure code that corresponds to the service provided
• The fee charged
• The tooth number/letter and surface/arch, where appropriate

If you are completing your own claim form and do not have access to the necessary information, you should contact your dentist for assistance.

**Filling out an Overseas Claim Form**

Overseas claim forms must be completed, signed and submitted, along with the detailed original receipt obtained from the dentist, to Delta Dental. The overseas claim form should include the enrollee’s/patient’s current address and phone number and/or email address so Delta Dental can contact you with any questions.

**Claims Submission Deadline**

Claims for covered services should be completed and submitted to Delta Dental as soon as possible after the service is provided. Claims must be received by Delta Dental within 12 months of the date of service in order to be processed. Claims received on or after the first day of the month following 12 months of the date of service will be denied by Delta Dental.

Participating network dentists cannot charge a TRDP patient for Delta Dental’s portion of the fee for services that Delta Dental denies because the claim was submitted late.

**Claims Payment**

Payment for any single procedure that is a covered service (except orthodontic treatment as described in this booklet) will be made upon completion of the procedure and submission of the claim.

• Claim payments for enrollee reimbursements are mailed to the enrollee’s address on file with DEERS and can be delayed if name/address records are not kept current. If you move or have other changes to your enrollment information, be sure to update it in DEERS.

• Claim payment checks with invalid address information will be held at Delta Dental until current information is reported. Checks will be voided after 365 days from the date of issue.

• When a replacement check is reissued, a stop payment will be placed on the original claim payment check so that it will be invalid if it should appear later. If uncertain about the check status, call Customer Service to verify if the check is valid.

• A request to cancel a check must be made in writing and will be granted only if fraudulent circumstances are suspected (e.g., identity theft, mail theft, embezzlement, etc.).

• Checks that are returned to Delta Dental for reprocessing must indicate the reason for the return.
Payment to Participating Network Dentists
Delta Dental will pay participating network dentists and Delta Dental Premier® dentists directly. We have an agreement with these dentists to make sure that you will not be responsible to the dentist for any money Delta Dental owes.

Payment to Out-of-Network Dentists
Delta Dental will pay the subscriber directly when a non-Delta Dental dentist is selected for treatment unless the Assignment of Benefits section on the claim form has been signed by the subscriber, thereby authorizing direct payment to the dentist.

Payment to Overseas Dentists
Overseas enrollees will need to pay in full at the time of service and must submit their claims directly to Delta Dental to be reimbursed. Delta Dental will convert the fees submitted on overseas claims to U.S. dollars and make payment directly to the subscriber in U.S. dollars based on the date of service. Enhanced TRDP benefits are not assignable to dentists overseas.

Pre-treatment Estimates
Pre-treatment estimates are not required though are recommended for more complex and major procedures such as cast crowns, bridges and dentures. The pre-treatment estimate request outlines the dentist’s proposed treatment plan on a claim form and should include specific procedure code(s) and x-rays, if needed. Dates of service are left blank, because the treatment is only proposed and not yet completed.

Delta Dental will process the pre-treatment estimate request and issue a Pre-treatment Estimate Notice to the dentist. A copy of the notice will be sent to the patient. The Pre-treatment Estimate Notice is Delta Dental’s non-binding, written estimate of how much the Enhanced TRDP will cover for a particular service.

When the treatment is complete, the dentist will fill in the date(s) of service, sign and return the Pre-treatment Estimate Notice to Delta Dental at the address provided for submitting claims (see “Claims Submission”). Pre-treatment Estimate Notices submitted for payment will be processed in accordance with Delta Dental’s claims processing policies. The final determination of eligibility, maximums, program benefits, limitations and allowable fees will be made by Delta Dental when the Pre-treatment Estimate Notice is processed as a claim for payment.

Coordination of Benefits (COB)
You may have other dental coverage in addition to the TRDP. For example, this may occur if the subscriber has another job or if the subscriber’s spouse has a job and has dental benefits through that job.

If you are covered by another dental plan, it is your responsibility and to your advantage to let your dentist and Delta Dental know. Most dental carriers coordinate benefits when secondary coverage is noted on the claim, allowing patients to make use of their coverage under both programs. Payment is based on the type of benefit programs involved (e.g., fee for-service, indemnity, preferred provider organization (PPO), etc.) and the guidelines for coordination between these programs as established by the National Association of Insurance Commissioners.

If the dental office is completing the claim form, ask that they complete the “Other coverage” portion of the claim to ensure that all benefits are appropriately coordinated. If you are submitting your own claim, follow the COB rules outlined below to determine which carrier is primary and which is secondary, and be sure to include complete information about your other coverage carrier.
In cases where there is other dental coverage, the following Coordination of Benefits rules determine coverage and payment:

- The claim should be filed first with the plan that pays first. Information about the first plan’s payment is used by the other plan to determine its payment. If Delta Dental pays first, the other plan will determine how much it will pay after the Delta Dental 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.

- Delta Dental will generally make the first payment if the other coverage is not principally a dental program.

- If the subscriber (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.

- 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.

If a child is covered under two different plans, the first coverage to pay usually depends on which parent’s birthday is earlier in the year. For example, if the mother was born on May 1 and the father was born on May 5, all the children will be covered by their mother’s plan first. This is because the mother’s birthday is earlier in the year than the father’s. The parents’ year of birth does not matter—only the month and day are considered. This “birthday rule” is defined by the National Association of Insurance Commissioners.

In custody cases, the determination of first coverage and second coverage can be difficult. In most cases, if one parent has been awarded custody, the child is covered by that parent’s coverage first and by the non-custodial parent’s coverage second. If the parent with custody remarries, his or her coverage usually 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 may pay first and the non-custodial parent’s coverage pays second. Sometimes it is not possible to determine which coverage should pay first even after checking these rules. In this case, whichever dental plan has covered the person the longest usually pays first. In special circumstances, a court may decide that some other rule should apply.

The Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) is a computer-generated statement that explains how a claim is processed. After Delta Dental has processed your claim, you will receive an EOB that shows what services were covered and the amount of your cost share, if any.

The ability to sign up for paperless EOBs eliminates having to wait for your paper copy to arrive in the mail. Instead, when you sign up for optional paperless EOBs you will get an email notification from Delta Dental whenever a new claim is processed; then you can immediately log on to the Consumer Toolkit® to view your EOB online. Sign up to “go paperless” on the website at trdp.org.
**How to Read Your EOB**

Page one of the EOB

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| **1** | **John Smith**  
123 Main Street  
Anytown, CA 12345-6789 | **2** | **Summary of your claim** |
| | | **Total amount of claim:** $335.00 | **Amount paid to your dentist:** $150.00 | **Amount paid by another plan:** $0.00 | **Amount you owe your dentist:** $0.00 |
| **3** | **Important Notice**  
This is a custom field. TRDP puts important notices in this area for our enrollees. | **4** | **About your dental benefits statement** |
| | | Payment for these services is determined in accordance with the specific terms of your dental plan and/or Delta Dental’s agreements with its participating dentists. Delta Dental’s payment decisions do not qualify as dental or medical advice. You must make all decisions about the desirability or necessity of dental procedures and services with your dentist. | **5** | **Appeals Information** |
| | | If you dispute the denial of payment of your claim in whole or in part, you may submit a written request for reconsideration of the denial. Your written request must |

The following information will be shown on the first page of your EOB:

1. The name and mailing address of the subscriber as it appears on the Delta Dental’s records.

2. Summary of your claim:
   
   (a) Total amount of claim: The total amount of the fees submitted by the dentist for the services on this claim. Submitted fees are those normally charged by the dentist for services provided to all patients, regardless of insurance coverage. The total amount of the claim (submitted fees) may be higher than the fees TRDP participating network dentists have agreed to accept for covered services, but participating network dentists have agreed not to charge the TRDP patient any difference between the submitted amount and the approved or allowed amount. The total amount of the claim shown here should be the same as the claim total (field 22) shown on page 2 of the EOB.
   
   (b) Amount paid to your dentist: The amount paid by Delta Dental for the services on this claim, after deductibles and cost shares were applied, where appropriate.
   
   (c) Amount paid by another plan: The amount paid by the other carrier when the patient is covered by more than one dental plan and Coordination of Benefits rules are applied.
   
   (d) Amount you owe your dentist: The amount the patient is responsible or paying after the deductibles and cost shares were applied, where appropriate.

3. Important Notice: This area is used by Delta Dental to provide important notifications to TRDP enrollees.

4. About your dental benefits statement: An explanation of how payment of the services provided on the claim is determined.

5. Appeals Information: Important information about how to request a reconsideration of a claim denial of payment and to report any suspected fraudulent activity regarding this claim.
The following information about your claim will be shown on the second page of your EOB:

- **Claim for XXXX**: The name of the patient (subscriber or family member) as it appears on the claim form.
- **Claim number**: The unique number Delta Dental uses to identify the claim associated with the EOB. You will need to reference this number if you contact us with questions about your EOB.
- **Treating dentist**: The DBA name of the business or dentist who provided the services.
- **The complete name of the group dental program (i.e., TRICARE Retiree Dental Program) applicable to the claim.**
- **Indicates the TRDP subgroup in which the patient is enrolled (Basic or Enhanced TRDP)**
- **The benefit year is the 12-month period to which the TRDP patient’s deductibles, maximums and other program provisions are applied.**
- **Procedure Number & Type of Service/Tooth Number & Surface**: The CDT code number currently assigned to the procedure that was provided, along with a description of that procedure and, if applicable, the number and surface(s) of the tooth that was involved in the procedure. The date the service was provided will appear just above this information.
- **Submitted Amount ($)**: The dollar amount normally charged by the dentist for services provided to all patients. The total of the submitted amount of the claim appears under the claim summary on page 1 of the EOB. Although the submitted amount may be higher than the fees that TRDP participating network dentists have agreed to accept for covered services, network dentists have agreed not to charge the TRDP patient any difference between the submitted amount and the approved or allowed amount.
- **Approved Amount ($)**: The dollar amount used to calculate the total cost share due for the services submitted on the claim.

  For covered services provided by a TRDP participating network dentist, the Approved Amount ($) is the same as the Allowed Amount ($), i.e., the amount the TRDP participating network dentist has agreed to accept for the covered service(s).
- For covered services provided by a Delta Dental dentist who does not participate in the TRDP network (e.g., a Delta Dental Premier® dentist), the Approved Amount ($) is the lesser of the network allowance or the out-of-network fee in the geographic area where the dentist practices.

- For covered services provided by an out-of-network dentist, the Approved Amount ($) is the lesser of the dentist’s Submitted Amount ($) or the out-of-network fee in the geographic area where the dentist practices.

- For non-covered services, theApproved Amount ($) is the Submitted Amount ($).

15 - Allowed Amount ($): The dollar amount used to calculate payment by Delta Dental based on the coverage percentage for the service(s) submitted on the claim.

- For covered services provided by a TRDP participating network dentist, the Allowed Amount ($) is the same as the Approved Amount ($), i.e., the amount the TRDP participating network dentist has agreed to accept for the covered service(s).

- For covered services provided by a Delta Dental dentist who does not participate in the TRDP network (e.g., a Delta Dental Premier® dentist), the Allowed Amount ($) is the lesser of the network allowance or the out-of-network fee in the geographic area where the dentist practices.

- For covered services provided by an out-of-network dentist, the Allowed Amount ($) is the lesser of the dentist’s Submitted Amount ($) or the out-of-network fee in the geographic area where the dentist practices.

- For non-covered services, the Allowed Amount ($) is zero.

16 - Amount Applied to Deductible ($): The dollar amount of the patient’s deductible, if any, that is applied to the service provided.

17 - Paid by Another Plan ($): The dollar amount paid by the other carrier when the patient is covered by more than one dental plan and Coordination of Benefits rules are applied. The total amount paid by the other carrier, if any, also appears under the claim summary on page 1 of the EOB.

18 - Plan Coverage (%): The percentage of the service covered by the TRDP. In the example shown, the first two procedures (D0120 and D1110) are covered by the TRDP at 100%, and the third procedure (D2150) is covered at 80%. The patient’s cost share for the service is equal to the percentage of the service not covered by the TRDP; for procedures D0120 and D1110 the patient’s cost share would be zero, and for procedure D2150, which is covered by the TRDP at 80%, the patient’s cost share percentage would be 20%.

19 - Delta Dental Pays ($): The dollar amount paid by Delta Dental for the treatment after deductibles, other carrier payments and coverage percentages were applied, where appropriate.

20 - Patient Pays ($): The dollar amount the patient is responsible for paying after deductibles, other plan payments and cost share percentages were applied, where appropriate. The TRDP patient should not pay more than the amount shown as “Patient Pays ($).”

21 - The code number(s) of the processing policy/policies applied to the procedure and/or claim, and a written explanation of how the procedure and/or claim were processed as indicated by the associated policy code number(s).

22 - The totals for all claim lines shown in columns 13 through 20.

23 - Lists the amount of the patient’s annual maximum amount remaining, if any, for the benefit year applicable to the claim.
Questions about Your EOB

Be sure to review the information on your EOB carefully and retain the EOB for future reference. If you have any questions about the dental treatment you received or the amount billed by the dentist, first contact your dentist. If your dentist is a participating TRDP network dentist and you need additional assistance or believe an error was made in processing your claim, please use the convenient online Customer Service Inquiry Form available at trdp.org, or call or write to us:

Delta Dental of California
Federal Government Programs
PO Box 537007
Sacramento, CA 95853-7007
Toll-free: 888-838-8737

For more prompt service, please attach a copy of your EOB to the inquiry form, or include a copy of the EOB when you write.
Appeals Procedure

Delta Dental will notify you on your Explanation of Benefits (EOB) if any claims for dental services are denied, in whole or in part, stating the specific reason or reasons for the denial. If you believe there is an error in processing your claim, please call Delta Dental’s Customer Service department. If there was an error, in most cases Delta Dental can reprocess the denial of your claim based on your phone call. If you still have concerns regarding the denial of a claim for your dental services, you (or your authorized representative, if applicable) may request a review of the denial by filing a first-level appeal.

First-Level Appeal: Reconsideration

To be considered as an appeal:

- The appealing party must file the request within 90 calendar days after the date of the notice of the initial denial termination (for example, within 90 calendar days of the date of an EOB informing the beneficiary of a denied or reduced claim).
- The request must be in writing and may be either mailed or faxed. (Due to requirements to verify the appealing party, electronically mailed appeals are not accepted.) The appeal should state the issue in dispute, and should include a copy of all supporting documentation (e.g., a copy of the EOB) necessary for the review.
- There must be a disputed question of fact which, if resolved in favor of the appealing party, would result in the authorization of TRICARE benefits.
- The issue must be appealable. Non-appealable issues are described on the following page.
- Send your request to:
  Delta Dental of California
  Federal Government Programs Appeals Department
  PO Box 537015
  Sacramento, CA 95853-7015

Second-Level Appeal: Formal Review

You may request a formal review by the Defense Health Agency (DHA) if Delta Dental’s reconsideration decision was unfavorable, the amount in dispute is equal to or greater than $50 and the appeal is filed within 60 calendar days from the date of Delta Dental’s first-level appeal response. No amount in dispute is required when the denial addresses predeterminations (denial for dental necessity). A request for formal review should be sent to:

  Defense Health Agency
  Appeals, Hearings and Claims Collection Division
  16401 E. Centretech Parkway
  Aurora, Colorado 80011-9066

Non-Appealable Issues

The following issues are not appealable:

- Regulatory provisions. Based on DHA regulations, a dispute involving a regulatory provision or contractually defined issue of the TRDP (such as which procedures are covered) are not processed as an appeal.
- Allowable charge. The amount of allowable cost or charge is not appealable because the methodology for determining the charge is established by the TRDP contract.
• Eligibility for the TRDP. A person’s TRDP eligibility is not appealable because this determination is specified in law and regulation.

• Denial of services by a dentist. The refusal of a dentist to provide services or to refer a beneficiary to a specialist is not an appealable issue. This type of correspondence is categorized as a grievance and is handled accordingly.

Persons Who May Submit an Appeal of Denied Dental Coverage

Persons who may submit an appeal of denied dental coverage are:

• The TRDP enrollee (including minors; however, a parent or guardian of a minor enrollee may represent the enrollee in an appeal).

• A representative of the TRDP enrollee, appointed by a court of competent jurisdiction to act on his or her behalf.

• An individual who has been appointed, in writing, by the TRDP enrollee to act as the enrollee’s representative.

Appeals of Denied Requests for Voluntary Termination

Requests for “voluntary termination” of TRDP coverage under the “grace period” or “extenuating circumstances” policies must be submitted in writing to Delta Dental at the “General Inquiries” address listed on the “Contact Information and Resources” page in the front of this booklet.

If the initial voluntary termination request is denied, you may file a written request for reconsideration. To be considered, the request must be submitted within 90 days of the date of the denial notice. It should include a copy of Delta Dental’s initial determination notice and relevant documentation supporting the request. Submit requests to:

Delta Dental of California
Federal Government Programs Appeals Department
PO Box 537015
Sacramento, CA 95853-7015

If the reconsideration is not in your favor, you may request a formal review from DHA, following the process for second-level appeals described above. The decision of DHA is the final determination.
Grievances

Delta Dental’s grievance process allows full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a participating network dentist or Delta Dental personnel to furnish the level or quality of care and/or service to which the beneficiary believes he or she is entitled. For this process to work efficiently, it is important that any grievance be submitted in writing to Delta Dental as soon as possible after the occurrence of the initial event that is the subject of the grievance, and prior to the beneficiary seeking additional care related to the initial event.

Persons Who May Submit a Grievance

Delta Dental’s policy is that any TRDP beneficiary, subscriber, parent, guardian or other representative who is aggrieved by a failure (or perceived failure) of Delta Dental’s staff or a participating network dentist to meet their obligations for timely, high-quality, appropriate care or service may file a written grievance. The subject of a grievance may be an issue such as:

- The refusal of a dentist to provide services or to refer a beneficiary to a specialist.
- The length of the waiting period to obtain an appointment or undue delays at an office when an appointment has been made.
- Improper level of care, poor quality of care or other factors that reflect upon the quality of the care provided.
- The quality and/or timeliness of an administrative service.
- A grievance must state it is a “formal grievance” and be submitted to:

  Delta Dental of California
  Federal Government Programs Grievance Department
  PO Box 537015
  Sacramento, CA 95853-7015

In lieu of a written letter, you can complete and submit your grievance by mail using the Patient Grievance Form, which is available for downloading from the TRDP website at trdp.org.
Quality of Care

If you have questions about the quality of services you receive from a participating TRDP network dentist or from a Delta Dental Premier\textsuperscript{\textregistered} dentist, we recommend that you first discuss the matter with the dentist. If you continue to have concerns, please complete the Patient Grievance Form and mail or fax the form to:

Delta Dental of California
Federal Government Programs Grievance Department
PO Box 537015
Sacramento, CA 95853-7015
Fax: 916-858-0235

Quality Assurance

Clinical Precautions in the Dental Office

Delta Dental shares public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist’s use of precautions against the spread of diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta Dental or to you. Delta Dental informs its network dentists about the need for clinical precautions as recommended by recognized health authorities and required for compliance with Occupational Safety and Health Administration regulations. If you have questions about your dentist’s health status or use of recommended clinical precautions, you should discuss them with your dentist.

Internal Quality Control

In addition to ongoing communication and outreach to both the dental and retired service member communities on quality of care issues, Delta Dental has established internal quality control procedures to help minimize program costs, ensure accurate and prompt claims processing, and maintain an optimum level of overall customer satisfaction with the TRDP. These quality control procedures are based on feedback from a variety of sources, including

- Internal audits
- Customer surveys
- Complaints, appeals and grievances
- Anecdotal comments from outreach staff

Results from this feedback are continuously reviewed and evaluated to determine the appropriate course of action to implement improvements. The ultimate goal of Delta Dental’s quality control plan is to exceed our customers’ expectations in the provision of dental benefits and customer service for the TRICARE Retiree Dental Program.
Fraud and Abuse

Although very few dentists engage in fraudulent activities, the damage they do far exceeds their numbers. If left unchecked, fraud inflates the cost of dental programs and can limit access to affordable dental coverage. One of the most common forms of dental program fraud is called “overbilling.”

Under the TRDP, you share in both the cost and decision making of your dental care by paying a percentage of some fees. Some dentists offer to accept the “covered” percentage of insurance payment as “full payment” and do not collect your cost share percentage. This practice is called overbilling. Although it sounds like a good deal, you should know that these dentists make up their losses by overcharging your program and possibly by performing more services than necessary, which eventually will increase your program’s cost.

Overbilling has been identified as unethical conduct by the American Dental Association and is specifically prohibited by law in many states. Waiver of the cost share or offering of any inducement or incentive to receive care is also prohibited by federal law as it is inflationary and can result in services being provided that may not be medically necessary. You can help keep your program costs down by not participating in overbilling schemes and by contacting Delta Dental if you suspect these activities.

Notice of Privacy Practices

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to inform you of how Delta Dental and its affiliates (“Delta Dental”) protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient’s health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.
Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.
- Uses and/or disclosures of PHI for payment. For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.
- Uses and/or disclosures of PHI for health care operations. For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.

**Other permitted uses and disclosures without an authorization**

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner’s request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers’ compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

**Disclosures Delta Dental makes with your authorization**

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.
YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.

Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt out of marketing that is permitted by law without an authorization. Delta Dental does not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.
You have the right to be notified following a breach of unsecured protected health information.
Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

COMPLAINTS
You may file a complaint with Delta Dental and/or with the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

CONTACTS
You may contact Delta Dental at 888-838-8737, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental
P. O. Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after January 1, 2016.

Note: Delta Dental’s privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.

LANGUAGE ASSISTANCE
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-888-838-8737.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-888-838-8737. (Spanish)
重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。
這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面的會員/客戶服務部的電話，或者撥打電話 1-888-838-8737。(Chinese)

Last significant changes to this notice:
• Clarified that Delta Dental does not use your PHI for fundraising purposes – effective January 1, 2016
• Clarified that Delta Dental’s privacy policy reflect federal and state requirements – effective January 1, 2015
• Updated contact information (mailing address and phone number) – effective July 1, 2013
• Updated Delta Dental’s duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
• Clarified that Delta Dental does not and will not sell your information without your express written authorization – effective July 1, 2013
• Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013
DELTA DENTAL AND ITS AFFILIATES

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee-for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia. Delta Dental of Pennsylvania’s affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nebraska, Texas and Utah and vision programs to groups headquartered in West Virginia.

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

Dentegra Insurance Company.
Basic Program Coverage

The Basic TRDP covers many dental services that are necessary and appropriate for improving and maintaining your dental health. To be considered for payment, dental services covered under the basic program must be provided by a licensed dentist practicing within the Basic TRDP service area, with the maximum cost savings available being realized when these covered dental services are provided by a participating TRDP network dentist.

Under the law which created the TRDP, the services which can be provided under the basic program are limited to basic dental care and treatment involving diagnostic, preventive, basic restorative, endodontic, periodontic, surgical, post-surgical, and emergency services. This section includes a general description of each of the categories of services that are covered under the Basic TRDP. Please refer to “Covered Services” for a detailed list of all covered services and general policies, limitations and exclusions that apply to the Basic TRDP.

Description of Covered Services

Diagnostic Services – Diagnostic procedures are those performed by the dentist to evaluate your dental health and identify any disease condition that might be present. Common diagnostic procedures include oral examinations and x-rays.

Preventive Services – Preventive procedures are those performed to help keep your teeth and their supporting structures healthy by preventing tooth decay and gum disease. Procedures in this category include cleanings and fluoride treatments.

Space Maintainers and Sealants – Space maintainers are appliances designed to save space for the proper eruption of permanent teeth. Sealants are applied to newly erupted molars to help prevent decay on the chewing surfaces.

Basic Restorative Services – Those procedures performed to restore a tooth’s anatomical form when a minimal amount of tooth structure has been lost due to dental caries or fracture are considered basic restorative services. This includes the use of silver and tooth-colored filling materials (tooth-colored filling material on anterior teeth only).

Endodontic Services – Endodontic procedures are for the treatment of diseases or injuries that affect the nerve and blood supply (pulp) of a tooth. A common endodontic procedure is root canal treatment.

Periodontic Services – Periodontic procedures are for the treatment of diseases of the supporting structures of the teeth such as bone and gum tissue. Services in this category include periodontal scaling, root planing and periodontal surgery.

Oral Surgery – Oral surgery procedures are surgical procedures performed to remove teeth or lesions in the oral cavity. These procedures include simple extractions and extractions of impacted teeth.

Emergency Services – These procedures are performed to determine the cause of pain and to provide the relief of pain on an emergency basis.

Other Services – Drugs (therapeutic drug injection and other medications dispensed in the dental office) and Post-surgical Services (treatment of complications following oral surgery).
Deductibles, Maximums and Cost Shares

Annual Deductible

The deductible is the specific dollar amount an enrollee must pay out of pocket toward covered services before the TRDP applies payment to those services. Each enrollee in the Basic TRDP must satisfy an annual benefit year deductible of $50 (the total annual deductible amount will not exceed $150 per family).

The annual deductible for each enrollee accrues over the benefit year (January 1 through December 31) regardless of when during the year an individual enrolled in the basic program and starts over beginning with each new benefit year. Any deductible balance remaining at the end of one benefit year does not carry over to the next year, nor do deductibles carry over to other TRICARE programs, such as an upgrade to the Enhanced TRDP.

Diagnostic and preventive services covered at 100% of the program allowed amount are not subject to the annual benefit year deductible. Refer to the “Covered Services” section in this booklet for detailed information on which services are not subject to the deductible.

Annual Maximum

The annual maximum is the total dollar amount the TRDP will pay per enrollee toward the cost of covered dental care during each benefit year. The Basic TRDP annual maximum is $1,000 per enrollee per benefit year for most covered services.

Diagnostic services and preventive procedures that are covered by the TRDP at 100% of the allowable amount are not subject to the annual maximum. This means that payment for services such as an oral examination or routine cleaning allowed during the benefit year does not count against the maximum and therefore does not reduce the $1,000 annual amount that Delta Dental pays toward a Basic TRDP enrollee’s dental care. Additionally, the annual maximum amount does not include monthly premiums or money spent for services not covered by the TRDP. Once an enrollee reaches his or her maximum, the enrollee is responsible for the total cost of any services obtained during the remainder of the benefit year.

The annual maximum for each enrollee accrues over the benefit year (January 1 through December 31) regardless of when during the year an individual enrolled in the basic program and starts over beginning with each new benefit year. Any balance remaining at the end of one benefit year does not carry over to the next year, nor do maximums carry over to other TRICARE programs, such as an upgrade to the Enhanced TRDP.

Services that are subject to the $1,000 annual maximum include:
- Sealants and space maintainers
- Basic restorative services
- Endodontic services
- Periodontic services
- Oral surgery, drugs and post-surgical services
- Emergency services

Your Cost Share

The TRDP pays a percentage of the program allowed amount for each covered service, subject to certain limitations. Your cost share depends on the type of service provided and whether care is provided by a participating network dentist or an out-of-network dentist (see “Selecting Your Dentist”). For example, basic restorative services are covered at 80% of the program allowed amount. If you visit a participating network dentist, you will be responsible only for the 20% cost share and deductible, if applicable; however, if you visit an out-of-network dentist, you will be responsible for the cost share and deductible, if applicable, as well as the difference between the program allowed amount and the dentist’s billed charges (or the dentist’s negotiated fee in the case of a Delta Dental Premier® dentist), if they are higher.
Dentists are required to collect your cost share for covered services. Failure to collect your cost share is called “overbilling” and could disqualify the dentist from participating in Delta Dental’s networks. If a dentist offers to waive your cost share or any part of it and accept payment from Delta Dental as payment in full, you should not accept such an offer. Please report any such incident to Delta Dental immediately.

The following chart provides an overview of the coverage percentage levels for services that are allowed under the Basic TRDP. A comprehensive, detailed list of all services covered under the Basic TRDP, including applicable procedure code numbers, policies, exclusions and coverage levels, can be found in “Covered Services” following this chart.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Percent of Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive</td>
<td>80%-100%</td>
</tr>
<tr>
<td>Restorative</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>60%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>60%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>80%-100%</td>
</tr>
<tr>
<td>Fixed Partial Denture Sectioning</td>
<td>60%</td>
</tr>
<tr>
<td>Drugs</td>
<td>60%</td>
</tr>
<tr>
<td>Post-surgical Services</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Deductible**

- Per patient, per benefit year: $50 (not to exceed $150 per family)

*Diagnostic and preventive procedures covered at 100% are exempt from the deductible.

**Annual Maximum**

- Per patient, per benefit year: $1,000

**Diagnostic and preventive procedures covered at 100% are exempt from the annual maximum.**
Covered Services

Procedures that are covered under the Basic TRDP are listed in this section. For further clarification, some services that are not covered are listed as exclusions. Please refer to the “Exclusions” at the end of this section for further details.

Some TRDP benefits are subject to time limitations that specify how often the benefit can be paid. Time limitations are indicated for services that 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:

The Basic TRDP pays for one cleaning in a rolling, 12-consecutive-month period (not the same as a calendar year). The rolling 12-month period starts with the date of the first covered cleaning in the time period; e.g., if you had your covered cleaning on March 2, 2016, the TRDP will not pay for another cleaning until March 2, 2017—12 months to the day from the previous paid cleaning—or after.

Time limitations are often designed to encourage you and your dentist to maintain a regular schedule for routine services such as exams and cleanings. If you are enrolled in the Basic TRDP, you might consider upgrading your coverage to the Enhanced TRDP—which pays for two cleanings in a 12-consecutive-month period, or three cleanings for diagnosed Type 1/Type 2 diabetics—so that you can get a second covered cleaning to the day with the same applicable time limitation. For more detailed information regarding time limitations for covered services listed below, please refer to the policies for each of the covered services listings.

Covered services for the Basic TRDP are determined by the Department of Defense and are based upon generally accepted dental practice standards. All covered services listed in this section conform to the most current version of the American Dental Association (ADA) Current Dental Terminology (CDT).

General Policies

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 contractors 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.

**Diagnostic Services**

Coverage: 100%

Patient Pays: 0%

Subject to Deductible: No

Applies to Maximum: No

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation—established patient</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with a primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation—new or established patient</td>
</tr>
<tr>
<td>D0160 R</td>
<td>Detailed and extensive oral evaluation—problem-focused</td>
</tr>
<tr>
<td>D0170 R</td>
<td>Re-evaluation—limited, problem-focused (established patient; not post-operative visit)</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation—new or established patient</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral—complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral—periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral—periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral—occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing—single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings—two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings—three radiographic images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings—four radiographic images</td>
</tr>
</tbody>
</table>
D0277    Vertical bitewings—seven to eight radiographic images
D0290    Posterior-anterior or lateral skull & facial bone survey radiographic image
D0330    Panoramic radiographic image
D0425    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 radiographic images includes bitewings. Any additional radiographic image taken with a complete radiographic image series is considered integral to the complete series.

8. A panoramic radiographic image taken with any other radiographic image 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 radiograph images equals or exceeds the fee for a complete series, these radiograph images 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 radiograph images within a 48-month period is the patient’s responsibility. If a full-mouth series is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional radiographic images.

11. Payment for panoramic radiographic image is limited to one within a 48-month period.

12. Payment for periapical radiographic images (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 radiographic image(s), including those taken as part of a complete series, is limited to one within a 12-month period.

14. Radiograph images of non-diagnostic quality are not payable.

15. Duplication of radiographic images 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 lifetime. They will not be paid if related to non-covered 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 non-covered medical or dental procedures.

**Preventive Services—100% coverage**

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult (one per 12-month period)</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis—child through age 13 (two per 12-month period)</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride—excluding varnish</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis—adult (one per 12-month period)</td>
</tr>
</tbody>
</table>

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. This limitation includes periodontal procedures D4910 and D4356, which are covered at 60%. Payment is limited to one prophylaxis or one periodontal procedure in 12 consecutive months. Payment for additional prophylaxes or periodontal procedures is the patient’s responsibility.
3. Two prophylaxes for children are covered in a period of 12 consecutive months to the day.
4. One fluoride treatment for adults and two fluoride treatments for children are to the day covered in a period of 12 consecutive months. This limitation includes procedure D1206, Topical application of fluoride varnish. 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.

**Preventive Services—80% coverage**

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: Yes
Applies to Maximum: Yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>
D1515  Space maintainer—fixed—bilateral
D1520  Space maintainer—removable—unilateral
D1525  Space maintainer—removable—bilateral
D1550  Recementation or re-bond of space maintainer
D1555  Removal of fixed space maintainer
D1575  Distal shoe space maintainer—fixed—unilateral

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

10. Sealants are payable once per tooth.

11. One sealant per tooth is covered in a three-year period.

12. Sealants are payable for first permanent molars that are free from caries and restorations on the occlusal surface for patients under age 9 and for second permanent molars for patients under age 14.

13. Sealants for teeth other than permanent molars or for teeth with restorations or decay on the occlusal surface or for patients over age 13 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. The fee for a space maintainer-type appliance done in conjunction with orthodontic treatment is not covered.

18. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are 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.

25. Distal shoe space maintainer (D1575) is a benefit to guide the eruption of the first permanent molar and is not covered for patients 14 years and older.

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
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. 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3120</td>
<td>Pulp cap—indirect (excluding final restoration)</td>
</tr>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy—anterior tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy—bicuspid tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy—molar tooth (excluding final restoration)</td>
</tr>
<tr>
<td>D3332</td>
<td>Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy—anterior</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy—bicuspid</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy—molar</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/ calcific repair of perforations, root resorption, etc.)</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery—anterior</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery—bicuspid (first root)</td>
</tr>
</tbody>
</table>
D3425   Apicoectomy/periradicular surgery—molar (first root)
D3426   Apicoectomy/periradicular surgery (each additional root)
D3427  Periradicular surgery without apicoectomy
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 tooth-bounded spaces per quadrant
D4211  R  Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant
D4240  R  Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant
Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant

Apically positioned flap

Osseous surgery (including elevation of a full-thickness flap entry and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant

Osseous surgery (including elevation of a full-thickness flap entry and closure)—one to three contiguous teeth or tooth-bounded spaces per quadrant

Bone replacement graft—retained natural tooth—first site in quadrant

Bone replacement graft—retained natural tooth—each additional site in quadrant

Guided tissue regeneration—resorbable barrier, per site

Guided tissue regeneration—non-resorbable barrier, per site (includes membrane removal)

Pedicle soft tissue graft procedure

Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position

Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position

Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site

Autogenous connective tissue graft procedure (including donor and recipient surgical sites)—each additional contiguous tooth, implant or edentulous tooth position in same graft site

Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)—each additional contiguous tooth, implant or edentulous tooth position in same graft site

Periodontal scaling and root planing—four or more teeth per quadrant

Periodontal scaling and root planing—one to three teeth per quadrant

Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation

Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis

Periodontal maintenance (following active therapy)

Unscheduled dressing change (by someone other than treating dentist or their staff)

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. Bone grafts, soft tissue grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of natural teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, existing implants or other non-periodontal surgical procedures.

7. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

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, periodontal maintenance and scaling in presence of generalized moderate or severe gingival inflammation (D4346).

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.

**Oral Surgery Services**

Coverage: 60%

Patient Pays: 40%

Subject to Deductible: Yes

Applies to Maximum: Yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants—deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth—soft tissue</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth—partially bony</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth—completely bony</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>D7260</td>
<td>Oroantral fistula closure</td>
</tr>
<tr>
<td>D7261</td>
<td>Primary closure of a sinus perforation</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
</tr>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue—hard (bone, tooth)</td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue—soft</td>
</tr>
<tr>
<td>D7290</td>
<td>Surgical repositioning of teeth</td>
</tr>
<tr>
<td>D7291</td>
<td>Transseptal fiberotomy/ supra crestal fiberotomy</td>
</tr>
</tbody>
</table>
D7310  Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7311  Alveoloplasty 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.

General Services
The Basic 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 procedure

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. 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.

Fixed Partial Denture Sectioning

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9120  Fixed partial denture sectioning

The following policies apply to fixed partial denture sectioning services:

1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.

3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.

Drugs

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9610  Therapeutic parenteral drug, single administration
D9612  Therapeutic parenteral drugs, two or more administrations, different medications
D9630  Drugs or medicaments dispensed in the office for home use
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:

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

Exclusions
Procedures that are covered under the Basic TRDP are listed above. 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. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.

17. Plaque control programs, oral hygiene instruction, and dietary instruction.

18. 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.


20. Premedication and inhalation analgesia.


22. Experimental procedures.

23. Telephone consultations.

24. Those performed by a provider who is compensated by a facility for similar covered services performed for members.

25. Those resulting from the patient’s failure to comply with professionally prescribed treatment.

26. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.

27. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.

28. Duplicate and temporary devices, appliances, and services.

29. All hospital costs and any additional fees charged by the dentist for hospital treatment.

30. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

31. Implants (materials implanted into or on bone or soft tissue), maintenance of implants or the removal of implants.

32. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

33. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.

34. Orthodontic services.

35. Prosthodontic services.

36. Cast crowns, inlays, onlays or partial crowns.

37. 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.
38. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.

39. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.

**Enhanced Program Coverage**

The Enhanced TRDP covers most dental services that are necessary and appropriate for improving and maintaining your dental health. To be considered for payment, covered dental services must be provided by a licensed dentist practicing within the Enhanced TRDP service area, with the maximum cost savings available being realized when these covered dental services are provided by a participating TRDP network dentist.

This section includes a general description of each of the categories of services that are covered under the Enhanced TRDP and information on dental accident coverage, emergency dental care overseas, and orthodontic services. Please refer to the “Covered Services” section in this booklet for a detailed list of all covered services and general policies, time limitations and exclusions that apply to the enhanced program.

**Description of Covered Services**

Diagnostic Services – Diagnostic procedures are those performed by the dentist to evaluate your dental health and identify any disease condition that might be present. Common diagnostic procedures include oral examinations and x-rays.

Preventive Services – Preventive procedures are those performed to help keep your teeth and their supporting structures healthy by preventing tooth decay and gum disease. Procedures in this category include cleanings and fluoride treatments.

Space Maintainers and Sealants – Space maintainers are appliances designed to save space for the proper eruption of permanent teeth. Sealants are applied to newly erupted molars to help prevent decay on the chewing surfaces.

Basic Restorative Services – Basic restorative services are procedures performed to restore a tooth’s anatomical form when a minimal amount of tooth structure has been lost due to dental caries or fracture. These include silver fillings (amalgam) and tooth-colored fillings (composite resin).

Major Restorative Services – Major restorative procedures are performed to restore a tooth’s anatomical form when a significant amount of tooth structure has been lost due to dental caries or fracture. These include cast crowns and onlays.

Endodontic Services – Endodontic procedures are for the treatment of diseases or injuries that affect the nerve and blood supply (pulp) of a tooth. A common endodontic procedure is root canal therapy. Implant Services – Dental implant services involve the surgical placement of specially designed devices within or on the jaws as a means of providing for the replacement of teeth.

Periodontic Services – Periodontic procedures are for the treatment of diseases of the supporting structures of the teeth such as bone and gum tissue. Services in this category include periodontal scaling and root planing and periodontal surgery.

Prosthodontic Services – Prosthodontic procedures are performed to replace a missing tooth or missing teeth. These procedures include fixed bridges and removable partial and full dentures.

Oral Surgery Services – Oral surgery procedures are surgical procedures performed to remove teeth or lesions in the oral cavity. These procedures include simple extractions and extractions of impacted teeth.

Orthodontic Services – Orthodontic procedures are performed to realign malpositioned teeth to improve a patient’s ability to chew. These procedures include the placement and maintenance of braces.
Emergency Services – These procedures are performed to determine the cause of pain and to provide the relief of pain on an emergency basis.

Dental Accident Services – Dental accident services include all covered procedures in the program, except for orthodontic procedures, that are performed to correct dental problems that result from external, traumatic accidents. These are paid under separate payment rules with a separate annual maximum.

Other Services – anesthesia (general anesthesia and intravenous sedation), Professional Consultation (diagnostic service provided by a dentist other than the treating dentist), Professional Visits (office visits after normal office hours), Drugs (therapeutic drug injection and other medications dispensed in the dental office), Post-surgical Services (treatment of complications following oral surgery) and Miscellaneous (occlusal guards and athletic mouthguards).

Summary of Coverage
The following types of services will be covered under the Enhanced TRDP when the services are determined to have been necessary and furnished in an appropriate manner consistent with generally accepted dental practice standards.

**Level I Benefit – Immediate Benefits include:**
- Diagnostic services
- Preventive services
- Basic restorative services
- Endodontic services
- Periodontic services
- Oral surgery services
- Emergency and post-surgical services
- Drugs
- Anesthesia
- Professional consultation and visits
- Post-surgical services
- Miscellaneous services

**Level II Benefit – After 12 Months Continuous Enrollment Level I Benefits PLUS:**
- Major restorative services (crowns and cast restorations)
- Implant services
- Prosthodontic services (fixed bridges and removable full/partial dentures)
- Orthodontic services

Under the Enhanced TRDP, there are a waiting period and specific time limitations for selected procedures. Please refer to the “Covered Services” section for details of procedures to which these apply.

**Waiting Period**
Eligibility under the Enhanced TRDP for some of the services described in this section is subject to a 12-month waiting period. Exceptions to this waiting period are made for new retirees who enroll within four months after their retirement as well as enrollees who have upgraded their coverage from the basic program to the Enhanced TRDP and other individuals listed below.

**New Enrollees**
New enrollees in the Enhanced TRDP are eligible for diagnostic and preventive services, minor restorative services,
periodontal services, endodontic services, oral surgery and dental accident coverage as soon as their coverage is effective. Additional benefits available after 12 months of continuous enrollment include coverage for cast crowns and other major restorative services, as well as bridges, dentures and orthodontics.

**Retirees Enrolled Within Four Months after Retirement**

An exception to the initial 12-month waiting period is made for individuals who enroll in the Enhanced TRDP within four months after their retirement from active duty or transfer to Retired Reserve status from the National Guard or the Reserves. These individuals may need to supply appropriate documentation (e.g., retirement orders, confirmation of Retired Reserve status, Chronological History of Drill Points) along with their enrollment application to verify their eligibility for this exception to the waiting period.

In addition to services available to new enrollees upon their coverage effective date, these individuals will be eligible for coverage for those procedures otherwise scheduled to become effective after 12 months of continuous enrollment, such as cast crowns and other major restorative services, bridges, dentures and orthodontics. The exception to the waiting period that is made for these specific individuals does not constitute a waiver of the minimum 12-month enrollment commitment that all enrollees must satisfy.

**Medal of Honor Recipients**

Medal of Honor (MOH) recipients and their immediate family members are also eligible for an exception to the initial 12-month waiting period. The 12-month waiting period exception will be granted for these individuals regardless of when they enroll. In addition to services available to new enrollees upon their coverage effective date, MOH recipients will be eligible for coverage for those procedures otherwise scheduled to become effective after 12 months of continuous enrollment, such as cast crowns and other major restorative services, bridges, dentures and orthodontics. The exception to the waiting period that is made for these specific individuals does not constitute a waiver of the minimum 12-month enrollment commitment that all enrollees must satisfy.

**Families of Deceased Active Duty**

Credit for the 12-month benefit waiting period will be applied to surviving family members whose enrollment in the TRDP takes place within four months of the termination of survivors’ coverage under the TRICARE Dental Program (TDP). Similarly, for surviving family members of service members who died while on active duty and the family members were not eligible for survivor coverage under the TRICARE Dental Program, waiting periods will not apply if enrollment is initiated within four months of the active duty service member’s death.

The same rules discussed under the “Retirees Enrolled within Four Months after Retirement” section above apply to these enrollees.

**Deductibles, Maximums and Cost Shares**

**Annual Deductible**

The deductible is the specific dollar amount an enrollee must pay out of pocket toward covered services before the TRDP applies payment to those services. Each enrollee must satisfy an annual benefit year deductible of $50. The total annual deductible amount will not exceed $150 per family.

The annual deductible for each enrollee accrues over the benefit year (January 1 through December 31) regardless of when during the year an individual enrolls in the enhanced program and starts over beginning with each new benefit year. Any deductible balance remaining at the end of one benefit year does not carry over to the next year, nor do deductibles from other TRICARE programs, such as the Basic TRDP.

Diagnostic and preventive services covered at 100% of the allowable amount, as well as orthodontic services and dental accident procedures, are not subject to the annual benefit year deductible. Refer to the “Covered Services” section in this booklet for detailed information on which services are not subject to the deductible.
Maximum Benefit Amounts

The maximum benefit is the total dollar amount the TRDP will pay per enrollee toward the cost of dental care over a defined period of time. The Enhanced TRDP has three types of maximum benefit amounts: (1) an annual maximum, (2) an annual dental accident maximum, and (3) a lifetime orthodontic maximum.

Annual Maximum

The annual maximum is the total dollar amount the TRDP will pay per enrollee toward the cost of covered dental care during each benefit year (except orthodontics and dental accident services). The TRDP annual maximum is $1,300 per enrollee per benefit year for most covered services. Diagnostic services and preventive procedures that are covered by the TRDP at 100% of the program allowed amount are not subject to the annual maximum. This means that payment for services such as oral examinations or routine cleanings allowed during the benefit year do not count against the maximum and therefore do not reduce the $1,300 annual maximum amount that Delta Dental pays toward an Enhanced TRDP enrollee’s dental care. Orthodontics and dental accident services have their own separate maximum benefit amounts.

Additionally, the annual maximum amount does not include monthly premiums or money spent for services not covered by the TRDP. Once an enrollee reaches his or her maximum, the enrollee is responsible for the total cost of any services obtained during the remainder of the benefit year.

The annual maximum for each enrollee accrues over the benefit year (January 1 through December 31) regardless of when during the year an individual enrolls in the Enhanced TRDP and starts over beginning with each new benefit year. Any balance remaining at the end of one benefit year does not carry over to the next year, nor do maximums from other TRICARE programs, such as the Basic TRDP or the active duty family member dental program (TRICARE Dental Program), apply to the Enhanced TRDP.

Services that are subject to the $1,300 annual maximum include:

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

Your Cost Share

The TRDP pays a percentage of the program allowed amount for each covered service, subject to certain limitations. Your cost share depends on the type of service provided and whether care is provided by a participating network dentist or an out-of-network dentist (see “Selecting Your Dentist”). For example, basic restorative services are covered at 80% of the program allowed amount. When you visit a participating network dentist, you will be responsible only for the 20% cost share and your deductible, if applicable. If you visit an out-of-network dentist, you will be responsible for the cost share and deductible, if applicable, and the difference between the program allowed amount and the dentist’s submitted charges or the dentist’s negotiated fee in the case of a Delta Dental Premier® dentist, if they are higher.

Dentists are required to collect your cost share for covered services. Failure to collect your cost share is called “overbilling” and could disqualify the dentist from participating in Delta Dental’s networks. If a dentist offers to waive your cost share or any part of it and accept payment from Delta Dental as payment in full, you should not accept such an offer. Please report any such incident to Delta Dental immediately.

The following chart provides an overview of the coverage percentage levels for services that are allowed under the Enhanced TRDP during the first 12 months of continuous enrollment and the additional services that are available after 12 months. A comprehensive, detailed list of all services covered under the Enhanced TRDP, including
applicable procedure code numbers, policies, exclusions and coverage levels, can be found in the “Covered Services” section of this booklet.

**Dental Accident Coverage**

Accidents that cause injury to the mouth may result in significant and expensive dental treatment. To help offset the cost of this treatment, dental accident coverage is included for enrollees in the Enhanced TRDP. Delta Dental will pay 100% of the program allowed amount, subject to the dental accident maximum, for dental accident treatment defined as TRDP covered services provided for conditions caused directly by external violent and accidental means. Services provided for the treatment of dental accidents are subject to all applicable general policies and exclusions of the TRDP.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Percent of Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 12 months of continuous enrollment</td>
<td></td>
</tr>
<tr>
<td>After 12 months of continuous enrollment</td>
<td></td>
</tr>
<tr>
<td>Diagnostic</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive</td>
<td>80%-100%</td>
</tr>
<tr>
<td>Restorative</td>
<td>80%</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>Endodontics</td>
<td>60%</td>
</tr>
<tr>
<td>Periodontics – removable and fixed</td>
<td>60%-100%</td>
</tr>
<tr>
<td>Prosthodontics – removable and fixed</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>Implant Services</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>80%-100%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>60%</td>
</tr>
<tr>
<td>Professional Consultation</td>
<td>60%</td>
</tr>
<tr>
<td>Professional Visits</td>
<td>60%</td>
</tr>
<tr>
<td>Drugs</td>
<td>60%</td>
</tr>
<tr>
<td>Post-surgical Services</td>
<td>60%</td>
</tr>
<tr>
<td>Miscellaneous Services</td>
<td>60%</td>
</tr>
<tr>
<td>Dental Accident</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Deductible***

Per patient, per benefit year $50 (not to exceed $150 per family)

**Annual Maximum**

Per patient, per benefit year $1,300

**Separate Dental Accident Coverage Maximum**

Per patient, per benefit year $1,200

**Separate Orthodontic Maximum**

Per patient, per lifetime $1,750

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1 Credit for the 12-month benefit waiting period will be granted to Medal of Honor recipients and to those individuals who elect to enroll in the TRDP within four months after their retirement from active duty, the National Guard or the Reserves. Those procedures scheduled to become effective after 12 months of continuous enrollment will be available to these enrollees immediately upon their coverage effective date.

A comparable credit shall be applied to surviving family members whose enrollment in the TRDP takes place within four months after the termination of survivors’ coverage under the TRICARE Dental Program (TDP). Similarly, for surviving family members of service members who died while on active duty and who were not previously covered under the TDP, waiting periods shall not apply if enrollment is initiated within four months after the active duty service member’s death.
Dental accident benefits are limited to services provided to an eligible person within 180 days following the date of the accident. Dental benefits under the Enhanced TRDP dental accident coverage do not include any services for conditions caused by an accident occurring before the enrollee’s effective date of coverage under the enhanced program. A separate annual maximum benefit amount of $1,200 per enrollee will be allowed for dental accident coverage. The annual deductible will 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.

**Annual Maximum Benefit for Dental Accident Coverage**

The separate annual maximum for procedures provided as a result of a dental accident is $1,200 per enrollee. The annual maximum for other services does not apply to dental accident procedures. The annual maximum for each enrollee will accumulate over each benefit year (January 1 through December 31) regardless of when during the year an individual enrolls in the enhanced program. Enrollees will have a new $1,200 annual maximum for dental accident coverage available at the beginning of each new benefit year. 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.

**Emergency Dental Care Overseas**

When traveling outside the enrollment area of 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, Enhanced TRDP enrollees will be covered only for emergency treatment as necessary. Enhanced TRDP enrollees who obtain emergency treatment outside the original enrollment area will be required to pay in full at the time services are rendered and must submit their own TRDP claims to Delta Dental for reimbursement. Reimbursement will be made to the enrollee in U.S. dollars, based on the exchange rate in effect at the time of service. Delta Dental does not send payment directly to dentists overseas.

The exception to this policy is an enrolled family member who is a full-time student overseas; this individual can receive comprehensive benefits under the Enhanced TRDP worldwide. (In order for TRDP claims to be processed for this individual, however, it is important that information regarding the enrolled family member’s student status be current in DEERS).

**Orthodontics**

Orthodontic coverage is available for both children and adults enrolled in the Enhanced TRDP after the initial waiting period of 12 months. A separate lifetime maximum of $1,750 is allowed for each enrollee for covered orthodontic procedures. There is no annual deductible for orthodontic treatment.

Orthodontic treatment is payable at 50% of the approved fee, subject to the lifetime orthodontic maximum 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. Payment for diagnostic services performed in conjunction with orthodontics is not applied to the enrollee’s annual or lifetime maximums.

**Patient Eligibility**

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

- The patient must be enrolled in the TRDP at the time the progress payment is scheduled. If a patient becomes eligible for TRDP 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 TRDP is terminated during the schedule of progress payments, no further progress payments are made.

• If a patient’s enrollment is terminated and the patient is re-enrolled during the original schedule of progress payments, a new claim must be submitted at the time the patient becomes eligible for orthodontic coverage. Payments will be made in accordance with the “Orthodontic Claims Processing and Payments” section below.

**Dentist Status**

Each orthodontic payment is also subject to validation of the dentist’s status as follows:

• If a dentist who does not participate in any Delta Dental network becomes either a dentist who participates in the TRDP network or a Delta Dental Premier® dentist during the schedule of progress payments, the progress payments will then be sent directly to the dentist rather than the subscriber.

• If a dentist no longer participates in any Delta Dental network during the schedule of progress payments, the progress payments will then be sent to the subscriber.

• 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.

**Orthodontic Claims Processing and Payments**

Unlike other services which are payable only 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.

**Cases Begun After Eligibility for Orthodontic Coverage**

• If the estimated treatment plan is more than 18 months, the initial payment of 25% 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 ........................................ $3,400
Cost share for orthodontic coverage .................. 50%
Maximum lifetime benefit allowed ...................... $1,750
Estimated length of active treatment .................. 24 months
Banding month ............................................. January 2016
Completion month ....................................... December 2017

Multiply total approved fee by cost share ($3,400 x 50%)   $1,700
Lesser of balance ($1,700) or orthodontic maximum ($1,750) $1,700
Total amount payable by Delta Dental .................. $1,700
Initial payment on 1/2016 ($1,700 x 25%) ................ $425
First progress payment on 6/2016 ....................... $425
Second progress payment on 12/2016 .................... $425
Third progress payment on 6/2017 ....................... $425

• 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 ........................................ $1,800
Cost share for orthodontic coverage .................. 50%
Maximum lifetime benefit allowed ...................... $1,750
Estimated length of active treatment .................. 14 months
Banding month ............................................. January 2016
Completion month ....................................... February 2017

Multiply total approved fee by cost share ($1,800 x 50%)   $900
Lesser of balance ($900) or orthodontic maximum ($1,750) $900
Total amount payable by Delta Dental .................. $900
Initial payment on 1/2016 ($900 x 25%) ................ $225
First progress payment on 5/2016 ....................... $225
Second progress payment on 10/2016 ................. $225
Third progress payment on 2/2017 ...................... $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 cost share for orthodontic coverage (50%) is applied to the treating dentist’s total approved fee. This determines the amount on which program payment is based.
• 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 first month of eligibility with the Enhanced TRDP through the orthodontic completion date. The proration amount is calculated by dividing the number of treatment months remaining by the post banding months. 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:

<table>
<thead>
<tr>
<th>Total approved fee</th>
<th>$5,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost share for orthodontic coverage</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum lifetime benefit allowed</td>
<td>$1,750</td>
</tr>
<tr>
<td>Estimated length of active treatment</td>
<td>24 months</td>
</tr>
<tr>
<td>Banding month</td>
<td>January 2016</td>
</tr>
<tr>
<td>Month patient is eligible for orthodontic coverage under the TRDP</td>
<td>June 2016</td>
</tr>
<tr>
<td>Completion month</td>
<td>December 2017</td>
</tr>
<tr>
<td>Number of months in active treatment remaining (6/2016—12/2017)</td>
<td>19 months</td>
</tr>
<tr>
<td>Number of post banding months</td>
<td>23 months</td>
</tr>
<tr>
<td>Proration calculation</td>
<td>19/23 = .826</td>
</tr>
</tbody>
</table>

| Multiply total approved fee by cost share ($5,200 x 50%) | $2,600 |
| Deduct banding fee ($2,600 x 30% = $780) | $1,820 |
| Lesser of prorated payable ($1,820 x .826 = $1,503.32) or orthodontic maximum ($1,750) | $1,503.32 |
| Total amount payable by Delta Dental | $1,503.32 |
| Initial payment on 6/2016 ($1,500 x 25%) | $375.83 |
| First progress payment on 11/2016 | $375.83 |
| Second progress payment on 5/2017 | $375.83 |
| Third progress payment on 11/2017 | $375.83 |

• 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.

**Covered Services**

Procedures that are covered under the Enhanced TRDP are listed in this section. For further clarification, some services that are not covered are listed as exclusions. Please refer to the “Exclusions” at the end of this section for further details.

Some TRDP benefits are subject to time limitations that specify how often the benefit can be paid. Time limitations are indicated for services that 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:

The Enhanced TRDP pays for two cleanings (or three for Type 1 and Type 2 diabetics) in a rolling, 12-consecutive-month period (not the same as a calendar year). The rolling 12-month period starts with the date of the first covered cleaning in the series; e.g., if you had your first covered cleaning on March 2, 2016 and a second covered cleaning on August 24, 2016, the TRDP will not pay for another cleaning until March 2, 2017—12 months to the day from the first paid cleaning—or after.
Time limitations are often designed to encourage you and your dentist to maintain a regular schedule for routine services such as exams and cleanings. For more detailed information regarding time limitations for covered services listed below, please refer to the policies for each of the covered services listings.

Covered services for the Enhanced TRDP are determined by the Department of Defense and are based upon generally accepted dental practice standards. All covered services listed in this section conform to the current version of the American Dental Association (ADA) Current Dental Terminology (CDT).

**General Policies**

1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (non-covered services) for billing purposes with the exception of dental services provided overseas.

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 network 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 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 benefits booklet, 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 network 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 contractors for specific instructions. Information is also available at 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 radiographic image is submitted with the dental claim.

**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 R** Detailed and extensive oral evaluation—problem-focused
- **D0170 R** Re-evaluation—limited, problem-focused (established patient; not post-operative visit)
- **D0171 R** Re-evaluation—post-operative visit
- **D0180** Comprehensive periodontal evaluation—new or established patient
- **D0210** Intraoral—complete series of radiographic images
- **D0220** Intraoral—periapical first radiographic image
- **D0230** Intraoral—periapical each additional radiographic image
- **D0240** Intraoral—occlusal radiographic image
- **D0250** Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector
- **D0251** Extra-oral posterior dental radiographic image
- **D0270** Bitewing—single radiographic image
- **D0272** Bitewings—two radiographic images
- **D0273** Bitewings—three radiographic images
- **D0274** Bitewings—four radiographic images
- **D0277** Vertical bitewings—seven to eight radiographic images
- **D0290** Posterior-anterior or lateral skull and facial bone survey radiographic image
- **D0330** Panoramic radiographic image
- **D0340** 2D cephalometric radiographic image—acquisition, measurement and analysis
- **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. Post-operative visit (D0171) includes all necessary post-operative care and re-evaluations by the same dentist/dental office who performed/submitted the original procedure.

8. A full-mouth series (complete series) of radiographic images includes bitewings. Any additional radiographic image taken with a complete radiographic image series is considered integral to the complete series.

9. A panoramic radiographic image taken with any other radiographic image is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.

10. If the total fee for individually listed radiographic images equals or exceeds the fee for a complete series, these radiographic images are paid as a complete series and are subject to the same benefit limitations.

11. Payment for more than one of any category of full-mouth radiographic images within a 48-month period is the patient’s responsibility. If a full-mouth series (complete series) is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional radiographic images.

12. Payment for panoramic radiographic images is limited to one within a 48-month period.

13. Payment for periapical radiographic images (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.

14. Payment for a bitewing survey, whether single, two, three, four or vertical radiographic image(s), including those taken as part of a complete series, is limited to one within a 12-month period.

15. Radiographic images of non-diagnostic quality are not payable.

16. Duplication of radiographic images for administrative purposes is not payable.

17. Test reports must describe the pathological condition, type of study and rationale.

18. 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.

19. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

20. Detailed and extensive oral evaluations (D0160) are limited to once per patient per dentist, per year. They will not be paid if related to non-covered medical or dental procedures.
21. 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 non-covered medical or dental procedures.

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

23. 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)
D1206  Topical application of fluoride varnish
D1208  Topical application of fluoride—excluding varnish

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 non-diabetic adults and children are covered in a period of 12 consecutive months to the day. One procedure D4910 or D4346 can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may also substitute both prophylaxes with one procedure D4910 or D4346 covered at 100% and a second one covered at 60%. Payment for additional cleanings is the non-diabetic patient’s responsibility.

3. Three prophylaxes for adults and children with Type 1 or Type 2 diabetes are covered in a period of 12 consecutive months to the day. One procedure D4910 or D4346 can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may substitute two prophylaxes with one procedure D4910 or D4346 covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one procedure D4910 or D4346 covered at 100% and the second and third procedures covered at 60%. A statement from the patient’s physician documenting the patient’s medical condition must be provided.

4. Two fluoride treatments for both adults and children are covered in a period of 12 consecutive months. This limitation includes procedure D1206, Topical application of fluoride varnish. Payment for additional fluoride treatments is 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.
Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

**Preventive Services—80% coverage**

Coverage: 80%
Patient Pays: 20%
Subject to Deductible: yes
Applies to Maximum: yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351</td>
<td>Sealant—per tooth</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in a moderate-to-high-caries-risk patient—permanent tooth</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer—fixed—unilateral</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer—fixed—bilateral</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer—removable—unilateral</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer—removable—bilateral</td>
</tr>
<tr>
<td>D1550</td>
<td>Recementation or re-bond of space maintainer</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer—fixed—unilateral</td>
</tr>
</tbody>
</table>

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 provided 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. 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).
19. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.
20. Repair of a damaged space maintainer is not covered.
21. Recementation of space maintainers is payable once within 12 months.
22. Space maintainers are not covered for patients 14 years and older.
23. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by Delta Dental or chargeable to the patient by a participating network dentist.
24. Distal shoe space maintainer (D1575) is a benefit to guide the eruption of the first permanent molar and is not covered for patients 14 years and older.
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
D2393  Resin-based composite—three surfaces, posterior
D2910  Recement or re-bond inlay, onlay, veneer or partial coverage restoration
D2915  Recement or re-bond indirectly fabricated or prefabricated post and core
D2920  Recement or re-bond crown
D2929  Prefabricated porcelain/ceramic crown—primary tooth
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

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-, two- and three-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. An allowance for comparable amalgam restorations with a patient cost share of 20% is allowed when the patient opts for non-covered resin procedure code D2394 (resin-based composite-four or more surfaces, posterior) on posterior teeth. The patient is responsible for the difference between the dentist’s charge for the posterior resin and the TRDP paid amount.

10. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.

11. 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.

12. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 36 months is not covered.

13. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.

14. Pin retention and buildups on primary teeth are covered in the fee for the restoration.

15. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.

16. Recementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.

17. After six months from the initial cementation date, recementation of crowns is payable once within 12 months.

18. Payment for a prefabricated resin crown (D2932) will be made when resin-based composite crowns are performed.

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

20. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

21. Facings on crowns posterior to the first molar position are considered to be cosmetic components. An allowance is made for a full cast crown.

22. After six months from the initial cementation date, recementation of cast crowns is payable once within 12 months.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.
31. 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.

32. Cast restorations and substructures include pins. A separate fee is not covered.

33. Veneers are not covered benefits. An allowance will be made for a resin restoration on an anterior tooth based on the degree of breakdown.

34. Porcelain/ceramic inlays and onlays are not covered benefits. An alternate benefit allowance toward porcelain/ceramic inlay may be made with a corresponding amalgam restoration on a posterior tooth, anda resin restoration on an anterior tooth. An optional benefit allowance toward a porcelain/ceramic onlay may be made with a metallic onlay.

35. The completion date for crowns, onlays and buildups is the cementation date.

36. Resin or metallic inlays and resin onlays are not covered benefits. An alternate benefit allowance may be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.

37. Glass ionomer restorations are not covered benefits.

38. Gold foil restorations are not covered benefits.

39. 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** Endodontic therapy, anterior tooth (excluding final restoration)
- **D3320** Endodontic therapy, bicuspid tooth (excluding final restoration)
- **D3330** Endodontic therapy, molar tooth (excluding final restoration)
- **D3332** Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
- **D3346** Retreatment of previous root canal therapy—antero
- **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—bicuspis (first root)
D3425  Apicoectomy/periradicular surgery—molar (first root)
D3426  Apicoectomy/periradicular surgery (each additional root)
D3427  Periradicular surgery without apicoectomy
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 dentist/same office).

**Periodontic Services – 100% coverage**

Coverage: 100%
Patient Pays: 0%
Subject to Deductible: No
Applies to Maximum: No
D4346  Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation
D4910  Periodontal maintenance (one per 12-month period when substituted – see policies below)
The following policies apply to periodontic services covered at 100%:

1. For non-diabetic adults and children in active periodontal therapy, one procedure D4910 or D4346 may be substituted for one of the annual routine prophylaxes and be covered at 100% within a consecutive 12-month period. The patient may also substitute both prophylaxes with one procedure D4910 or D4346 covered at 100% and a second one covered at 60% (see Preventive Services above).

2. For adults and children with Type 1 or Type 2 diabetes who are in active periodontal therapy, one procedure D4910 or D4346 can be substituted for one of the three prophylaxes and be covered at 100% in a period of 12 consecutive months to the day. The patient may substitute two prophylaxes with one periodontal procedure D4910 or D4346 covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one procedure D4910 or D4346 covered at 100% and the second and third procedures covered at 60%. A statement from the patient’s physician documenting the patient’s medical condition must be provided (see Preventive Services above).

**Periodontic Services – 60% coverage**

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4245</td>
<td>Apically positioned flap</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening—hard tissue</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full-thickness flap entry and closure)—four or more contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full-thickness flap entry and closure)—one to three contiguous teeth or tooth-bounded spaces per quadrant</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone replacement graft—retained natural tooth—first site in quadrant</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone replacement graft—retained natural tooth—each additional site in quadrant</td>
</tr>
<tr>
<td>D4266</td>
<td>Guided tissue regeneration—resorbable barrier, per site</td>
</tr>
<tr>
<td>D4267</td>
<td>Guided tissue regeneration—non-resorbable barrier, per site (includes membrane removal)</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>D4273</td>
<td>Autogenous subepithelial connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position</td>
</tr>
<tr>
<td>D4277</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position</td>
</tr>
<tr>
<td>D4278</td>
<td>Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4283</td>
<td>Autogenous connective tissue graft procedure (including donor and recipient surgical sites)—each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing—four or more teeth per quadrant</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing—one to three teeth per quadrant</td>
</tr>
</tbody>
</table>
D4355 R  Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4910  Periodontal maintenance (following active therapy)
D4920 R  Unscheduled dressing change (by someone other than treating dentist or their staff)

The following policies apply to periodontic services covered at 60%:

3. 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.

4. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.

5. 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.

6. 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.

7. 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.

8. Bone grafts, soft tissue grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of natural teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, existing implants or other non-periodontal surgical procedures.

9. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

10. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.

11. 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.

12. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery, periodontal maintenance and scaling in presence of generalized moderate or severe gingival inflammation (D4346).

13. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.

14. Up to two D4910 or D4346 procedures may be paid within a consecutive 12-month period for non-diabetic enrollees and up to three D4910 or D4346 procedures may be paid within a consecutive 12-month period for diabetic enrollees (see policies 1 and 2 applicable to periodontic services covered at 100%, above).

15. Full-mouth debridement is a benefit once per patient per lifetime.

16. One crown lengthening per tooth, per lifetime, is covered.

17. 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.

18. Subepithelial connective tissue grafts are payable at the level of free soft tissue grafts.

19. 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 Services, 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)
- **D5221** Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
- **D5222** Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
- **D5223** Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- **D5224** Immediate 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—per tooth
- **D5640** Replace broken teeth—partial denture, per tooth
- **D5650** Add tooth to existing partial denture
- **D5660** Add clasp to existing partial denture—per tooth
- **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 Services, Fixed**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210 X</td>
<td>Pontic—cast high noble metal</td>
</tr>
<tr>
<td>D6211 X</td>
<td>Pontic—cast predominantly base metal</td>
</tr>
<tr>
<td>D6212 X</td>
<td>Pontic—cast noble metal</td>
</tr>
<tr>
<td>D6214 X</td>
<td>Pontic—titanium</td>
</tr>
<tr>
<td>D6240 X</td>
<td>Pontic—porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6241 X</td>
<td>Pontic—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6242 X</td>
<td>Pontic—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6245 X</td>
<td>Pontic—porcelain/ceramic</td>
</tr>
<tr>
<td>D6545 X</td>
<td>Retainer—cast metal for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6548 X</td>
<td>Retainer—porcelain/ceramic for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6549 X</td>
<td>Resin retainer—for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6610 X</td>
<td>Retainer onlay—cast high noble metal, two surfaces</td>
</tr>
<tr>
<td>D6611 X</td>
<td>Retainer onlay—cast high noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6612 X</td>
<td>Retainer onlay—cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6613 X</td>
<td>Retainer onlay—cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6614 X</td>
<td>Retainer onlay—cast noble metal, two surfaces</td>
</tr>
<tr>
<td>D6615 X</td>
<td>Retainer onlay—cast noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6634 X</td>
<td>Retainer onlay—titanium</td>
</tr>
<tr>
<td>D6740 X</td>
<td>Retainer crown—porcelain/ceramic</td>
</tr>
<tr>
<td>D6750 X</td>
<td>Retainer crown—porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6751 X</td>
<td>Retainer crown—porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6752 X</td>
<td>Retainer crown—porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6780 X</td>
<td>Retainer crown—¾ cast high noble metal</td>
</tr>
<tr>
<td>D6781 X</td>
<td>Retainer crown—¾ cast predominantly base metal</td>
</tr>
<tr>
<td>D6782 X</td>
<td>Retainer crown—¾ cast noble metal</td>
</tr>
<tr>
<td>D6783 X</td>
<td>Retainer crown—¾ porcelain/ceramic</td>
</tr>
</tbody>
</table>
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 14 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 or fixed prosthesis 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 alternate 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
D6013  Surgical placement of mini-implant
D6050  Surgical placement: transosteal implant
D6056  Prefabricated abutment—including modification and placement
D6057  Custom fabricated abutment—including 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)
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6090 R Repair implant supported prosthesis
D6094 Abutment supported crown (titanium)
D6095 R Repair implant abutment and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6104 Bone graft at time of placement
D6110 Implant/abutment supported removable denture for edentulous arch—maxillary
D6111 Implant/abutment supported removable denture for edentulous arch—mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch—maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch—mandibular
D6114 Implant/abutment supported fixed denture for edentulous arch—maxillary
D6115 Implant/abutment supported fixed denture for edentulous arch—mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch—maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch—mandibular
D6194 Abutment supported retainer crown for FPD (titanium)

The following policies apply to implants:

1. Implant services are subject to a 50% cost-share and the annual program maximum.
2. Implant services are not eligible for members under age 14 unless submitted with x-rays and approved by Delta Dental.
3. 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.
4. 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.

5. 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.

6. Bone grafts in conjunction with implants are only a covered benefit at the time of implant placement.

**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  Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

D7220  Extraction, impacted tooth—soft tissue

D7230  Extraction, impacted tooth—partially bony

D7240  Extraction, impacted tooth—completely bony

D7250  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  Exposure of an unerupted tooth

D7283  Placement of device to facilitate eruption of impacted tooth

D7285  Incisional biopsy of oral tissue—hard (bone, tooth)

D7286  Incisional biopsy of oral tissue—soft

D7290  Surgical repositioning of teeth

D7291  Transseptal fiberotomy/supra crestal fiberotomy

D7310  Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant

D7311  Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant

D7320  Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant

D7321  Alveoloplasty 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  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  R  Excision of pericoronal gingiva
D7972  R  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
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.

**General Services**

The Enhanced 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 procedure

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. 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.

Fixed Partial Denture Sectioning
Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes
D9120 Fixed partial denture sectioning

The following policies apply to fixed partial denture sectioning services:
1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.
2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.
3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.
Anesthesia
Coverage: 60%
Patient Pays: 40%
Subject to Deductible: yes
Applies to Maximum: yes
D9223 R Deep sedation/general anesthesia—each 15 minute increment
D9243 R Intravenous moderate (conscious) sedation/analgesia—each 15 minute increment

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 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 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 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  Drugs or medicaments dispensed in the office for home use

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  R  Occlusal guard
D9941  Fabrication of athletic mouth guard
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 all exclusions, 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. Services for which the member would have no obligation to pay in the absence of this or any similar coverage.
5. Services performed prior to the member’s effective coverage date.
6. Services 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. Services which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.
13. Services not meeting accepted standards of dental practice.
14. Services which are for unusual procedures and techniques.
15. Plaque control programs, oral hygiene instruction, and dietary instruction.
16. Laser Assisted New Attachment Procedure (LANAP), considered investigational in nature as determined by generally accepted dental practice standards.
17. 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.
18. Gold foil restorations.
19. Premedication and inhalation analgesia.
20. House calls and hospital visits.
21. Telephone consultations.
22. Services performed by a dentist who is compensated by a facility for similar covered services performed for members.
23. Services resulting from the patient’s failure to comply with professionally prescribed treatment.
24. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.
25. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
26. Duplicate and temporary devices, appliances, and services.
27. Experimental procedures.
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. 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.
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 when the enrollee is traveling overseas. An exception is made for full-time students studying overseas and for enrollees who live permanently overseas.
34. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.
35. 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.
36. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.
Glossary

Many words contained in this benefits booklet have specific meanings. The following definitions are provided to help enrollees in the Enhanced TRDP better understand their dental program and get the most from the important information contained in this booklet.

Adjunctive Dental Care
Dental treatment that is medically necessary in the treatment of a medical (not dental) condition. Only those procedures listed in the “Covered Services” section of this book are covered under the TRDP.

Allowed Amount
The dollar amount used to calculate payment by Delta Dental based on the coverage percentage for the service(s) submitted on the claim. See section on “The Explanation of Benefits (EOB)” in this booklet for details.

Amalgam
The most commonly used material for fillings in posterior (back) teeth, also called silver fillings.

Annual Dental Accident Maximum Benefit
The separate annual maximum for procedures provided as a result of a dental accident. See Maximum Benefit Amount.

Annual Maximum Benefit
The total dollar amount that can be paid by the TRDP per enrollee during each benefit year (except orthodontics and dental accident services). See Maximum Benefit Amount.

Anterior Teeth
The front teeth. Refers to the six upper and six lower teeth located towards the front of the mouth; includes incisors and cuspids.

Appeal
A formal procedure through which an enrollee in the TRDP or an authorized representative can request a review of the denial of payment of a claim for covered dental services.

Appealable Issue
An issue regarding the denial of payment of a claim for covered dental services for reasons other than those involving the rules and policies of the Enhanced TRDP as set forth by law or regulation.

Approved Amount
The dollar amount used to calculate the total cost share due for the service(s) submitted on the claim. See section on “The Explanation of Benefits (EOB)” in this booklet for details.

Assignment of Benefits
This term refers to the authorization that a subscriber/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.

Basic Services
The most commonly needed dental services to help maintain good dental health. These services include those dental procedures necessary to restore the teeth (other than cast crowns and cast restorations), oral surgery procedures such as extractions, endodontic procedures such as root canals, and periodontal procedures including gum surgery.
Beneficiary Web Enrollment (BWE)

The federal government website that provides Department of Defense personnel and their eligible family members the capability to manage their TRICARE enrollment.

Benefits

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

Benefits Booklet

A comprehensive, detailed explanation of the policies and benefits of the Enhanced TRDP.

Benefit Year

The twelve-month period to which each enrollee’s deductibles, maximums and other plan provisions are applied. The TRDP benefit year begins on January 1 and runs through December 31.

Bicuspids (Premolars)

The first and second bicuspids are the fourth and fifth teeth counting from the center of the mouth on each side and are found between the cuspid (canine tooth) and the first molar. A bicuspid has two points (cusps).

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, but not year) falls earlier in the calendar year is billed first. In cases of divorced or separated parents, other factors such as custodial and legal orders must be considered.

Bitewing Radiographic Image (X-ray)

A radiographic image exposed by x-rays that shows the portion of the upper and lower posterior (back) teeth above the gum line and enables the dentist to detect cavities between the teeth and under fillings.

By Report

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. By Report procedures are indicated in the benefits booklet by an R following the procedure code.

Calendar Year

The 12-month period beginning January 1 and ending December 31. The TRDP does not use a calendar year to determine benefit time limitations/frequencies.

Caries/Cavities

Commonly used terms for tooth decay.

Cast Restoration/Crown

Cast restorations (crowns, inlays and onlays) are usually made of gold and other metals and used most often when it is necessary to replace a large portion of tooth structure lost from decay or fracture. These restorations are custom-fit to the individual tooth, processed in a dental laboratory and permanently cemented in place.

CDT (Current Dental Terminology)

See Code on Dental Procedures and Nomenclature.
Claim Form
A standard form submitted by the dentist or patient to Delta Dental for reimbursement of dental services. The completed and signed form must contain the information necessary for consideration for payment of dental services.

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. This benefits booklet uses the most current version of the code at the time of printing.

Composite
A tooth-colored material used to fill a tooth. Composite fillings are also known as resin fillings.

Comprehensive Oral Examination
A thorough evaluation of the extraoral and intraoral hard and soft tissues and detailed recording of the findings. It may require interpretation of information acquired through additional diagnostic procedures. A comprehensive evaluation typically includes an evaluation and recording of the patient’s dental and medical history and a general health assessment, as well as an evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal (bite) relations, periodontal conditions (including periodontal charting), hard and soft tissue abnormalities, etc.

Contract
The written agreement between the 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, the contract, together with this benefits booklet, forms the terms and conditions of the benefits provided under the Enhanced TRDP.

Coordination of Benefits (COB)
A method of integrating benefits payable for the same patient under more than one dental plan. Benefits from all sources should not exceed 100% of the total charges.

Cost Share
The enrollee’s portion of the allowed fee for a covered procedure.

Coverage Effective Date
The date a TRDP enrollee may begin obtaining benefits. The coverage effective date is the first day of the month following acceptance of the enrollment application.

Covered Procedure/Service
A dental procedure or service provided and/or received in accordance with the policies of the TRDP for which benefit payment will be made by Delta Dental.

Cusp
The high point(s) on the chewing or biting surface of a cuspid, bicuspid or molar tooth.

Cuspid
The third tooth, counting from the center of the mouth to the back of the mouth. Cuspids have one rounded or pointed edge used for biting and tearing. Cuspids are commonly known as canine teeth or eye teeth.
Date of Service

The date a dental service was completed. In cases when more than one visit is necessary to complete a dental procedure, the date that the actual procedure is completed is considered the date of service. This is the date that should 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. The deductible amount is allocated to each person per benefit year but is capped so as not to exceed a specified amount per family per benefit year.

Defense Enrollment Eligibility Reporting System (DEERS)

A series of databases that provides information on benefits eligibility and entitlements and serves as the central source of identity, enrollment, and eligibility verification for members of the uniformed services, other personnel designated by the DoD, and their eligible family members.

Defense Finance and Accounting Service (DFAS)

The pay center for retirees of the Army, Navy, Air Force and Marine Corps. Upon notification of enrollment in the TRDP, DFAS is required to automatically deduct monthly allotments from the retiree’s pay to cover the TRDP premiums.

Defense Manpower Data Center (DMDC)

The agency that collects personnel, manpower, training, financial and other data for the Department of Defense and catalogs the history of personnel in the military and their families for purposes of health care, retirement funding and other administrative needs.

Delta Dental of California

A not-for-profit dental benefits administrator, Delta Dental of California is one of many Delta Dental Plans across the country that are members of Delta Dental Plans Association. Delta Dental of California administers the TRDP.

Delta Dental Premier® Network

A nationwide network of licensed dentists, established as a managed fee-for-service program, that supports the delivery of dental programs offered by Delta Dental. While they are not a part of the network supporting the TRDP, Delta Dental Premier® dentists offer additional benefits for TRDP enrollees.

Dental Implant

A device specially designed to be placed surgically within or on the mandibular or maxillary bone (lower or upper jaw) as a means of providing for dental replacement.

Diagnostic Services

Procedures performed by the dentist to identify the health of the teeth and supporting structures and areas in and around the mouth. The most common diagnostic procedures are examinations and radiographic images.

Dual Coverage

When an enrollee has coverage for dental care under more than one benefit (insurance) plan.

Eligibility

The criteria set forth by the United States Congress to determine who is allowed to enroll in the TRDP.

Endodontic Services

Dental services that involve the treatment of diseases or injuries that affect the nerve and blood supply of a tooth. A common endodontic procedure is root canal therapy.
Enrollment Grace Period
A period of 30 days from your coverage effective date during which time you may disenroll, provided you or any enrolled family members have not used any of the benefits of the Enhanced TRDP.

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

Explanation of Benefits (EOB)
A statement sent to the subscriber and to the dentist, when the dentist is paid directly by Delta Dental, showing dentist and patient information, the service(s) received, the allowable charge(s), the amount(s) billed, the amount(s) allowed by the program and the cost-share amount(s). For denied services, the EOB also explains why payment was not allowed and how to appeal that decision.

Extraction
The surgical removal of a tooth.

Federal Government Programs
The division of Delta Dental of California that administers the TRDP under a contract with the Department of Defense.

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

Fluoride
A naturally occurring element that helps to prevent dental decay. It is found in fluoridated water systems and many toothpastes. It may also be applied directly to the teeth by a dentist or dental hygienist.

Gingiva
The soft tissue that surrounds the necks of the teeth. Also referred to as the gums.

Grace Period
See Enrollment Grace Period.

Grievance
A formal procedure that offers an opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network dentist or Delta Dental personnel to furnish the level or quality of care and/or service to which the beneficiary believes he or she is entitled.

Impacted Tooth
An unerupted or partially erupted tooth that will not fully erupt because it is obstructed by another tooth, bone or soft tissue.

Incisal Angle
The corner of the incisal edge of an anterior (front) tooth.

Incisal Edge
The biting surface of a central or lateral incisor.

Incisors
The central and lateral incisors are the first and second teeth counting from the center of the mouth to the back of the mouth. These are the front teeth with flat edges used for biting.
Inlay
A laboratory-processed restoration (filling) made of metal, gold, acrylic or porcelain. This type of restoration does not involve the high points of the tooth (cusps). Inlays are not covered benefits of the TRDP; however, an allowance may be made for a corresponding amalgam restoration.

Lifetime Orthodontic Maximum Benefit
The separate maximum allowed for each enrollee per lifetime for covered orthodontic procedures. See Maximum Benefit Amount.

Maximum Benefit Amount
The total dollar amount per enrollee that Delta Dental will pay during a specific period of time for covered services as specified in the TRDP’s contract provisions. The Enhanced TRDP has three types of maximum benefit amounts: (1) an annual maximum amount allowed per enrollee per benefit year for most covered procedures; (2) a separate maximum benefit amount allowed per enrollee per benefit year for dental accident procedures; and (3) a lifetime maximum benefit amount of allowed per enrollee for orthodontic procedures.

Network Dentist
A licensed dentist who is a member of a specific network of dentists who have agreed to accept negotiated fees for the provision of affordable dental care.

Non-Participating Dentist
See Out-of-Network Dentist.

Occlusal Surface
The chewing or grinding surfaces of the bicuspid and molar teeth (back teeth).

Onlay
A custom-made cast gold, semi-precious metal or porcelain restoration that is extended to cover the cusps for the protection of the tooth. It can also be used to replace one or more of the cusps of a tooth.

Oral Hygiene
The practice of personal hygiene of the mouth. It includes the maintenance of oral cleanliness, tissue tone, and general preservation of oral health through brushing and flossing.

Oral Surgery
Surgical procedures in and about the oral cavity and jaws, such as extractions.

Orthodontic Services
Dental procedures to realign teeth and/or jaws which otherwise do not function properly. The treatment usually consists of braces or other appliances to correct a patient’s bite, straighten the teeth and treat problems related to growth and development of the jaws.

Out-of-Network Dentist
A licensed dentist who is not a member of any participating TRDP network. While care may be received from an out-of-network dentist, enrollees may experience higher out-of-pocket costs than if using a participating network dentist. Delta Dental Premier® dentists, while considered out-of-network for the TRDP, offer benefits not available from other out-of-network dentists. (See “Out-of-Network Dentists” in the “Selecting Your Dentist” section of this booklet.)
Overbilling
The unethical practice whereby a dentist may offer to forego collection of a patient’s cost share as required by the TRDP and to accept the program’s “covered” percentage as payment in full. Overbilling by dentists is illegal and leads to increased costs for dental care and limits access to affordable dental coverage under programs such as the TRDP.

Palliative Treatment
Non-definitive treatment designed to alleviate pain or stop the spread of infection.

Panographic Radiograph (X-Ray)
An x-ray film exposed with both the x-ray source and film outside of the mouth that presents all of the teeth and jaws on one plane on a single film. Also known as a Panorex.

Participating Network Dentist
A licensed dentist who “participates” in the networks that support 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. See Network Dentist.

Periapical Radiograph (X-Ray)
An x-ray film that shows the whole root of a tooth, including the bone surrounding the apex (tip or bottom) of the root. Also known as a single film or PA.

Periodic Oral Examination/Evaluation
An evaluation performed on a patient of record to determine any changes in the patient’s dental and medical health status since a previous comprehensive or periodic evaluation was performed.

Periodontal Prophylaxis (Cleaning)
A part of periodontal maintenance following active periodontal therapy. The periodontal prophylaxis includes removal of the supra and subgingival microbial flora and calculus, site specific scaling and root planing where indicated, and/or polishing of the teeth.

Periodontal Services
Services that involve the treatment of diseases of the gum or supporting structure (bone). A common periodontal service is a periodontal root planing.

Periradicular
The area that surrounds the root of the tooth.

Permanent Tooth
An adult tooth. Also known as permanent dentition. Adult teeth naturally replace primary (baby) teeth.

Posterior Teeth
The bicuspids and molars. These are the teeth in the back of the mouth used for chewing and grinding.

Prefabricated Crown
A pre-made metal or resin crown shaped like a tooth that is used to temporarily cover a seriously decayed or broken down tooth. Used most often on children’s deciduous teeth (baby teeth).
Premium
The monthly amount paid by an enrollee for coverage under TRDP.

Premium Prepayment
An advance payment that amounts to the first two months of premium that is required to be made at the time of application for enrollment in TRDP. Future premiums are then deducted from retirement pay. If it is determined that sufficient retirement pay is not available for premiums, other arrangements will be made.

Preventive Services
Dental services performed to prevent tooth decay and gum disease. Common preventive services include cleanings and fluoride treatments.

Pre-treatment Estimate
A non-binding written estimate by Delta Dental of how much the Enhanced TRDP will cover for a particular service. Pre-treatment estimate requests from dentists are suggested for the more complicated and expensive treatment plans.

Primary Teeth
A child’s first set of twenty teeth that are eventually replaced by permanent teeth. Also known as deciduous or baby teeth.

Procedure Codes
The American Dental Association (ADA) codes used to identify and define specific dental services. Only those dental services whose procedure codes are specifically listed in this benefits booklet are covered under the Enhanced TRDP.

Prophylaxis (Cleaning)
Teeth cleaning; the scaling and polishing of the crowns of the teeth to remove calculus, plaque (a sticky bacterial substance that clings to the surface of the teeth and causes caries and gum disease), and stains. Also known as a prophy.

Prosthodontic Services
Dental services that involve the design, construction, and fitting of fixed bridges and partial and complete dentures to replace missing teeth or restore oral structures.

Provider
A dentist or other person who is licensed by a state to deliver dental services.

Proximal Surface
Refers to the surfaces of a tooth that touch an adjacent tooth. The space between adjacent teeth is the interproximal space.

Quadrant
One of the four equal sections of the mouth. The four quadrants of the mouth are the upper right, the upper left, the lower right and the lower left.

Radiograph
A picture produced on a sensitive surface (film) by a form of radiation other than light. In dentistry, x-rays are the radiation source. The term x-ray is often used interchangeably with radiograph.

Resin
See Composite.
Restorative Services
Dental procedures performed to restore the missing part of the tooth that was due to decay or fracture. A common restorative service is an amalgam (silver) filling.

Retired Pay Deduction
An automatic allotment deducted by the member’s Uniformed Services finance center before direct deposit into that member’s checking account. The automatic deduction of the monthly premium from retirement pay is by means of a discretionary allotment and is mandated by Public Law 104-201 for the TRICARE Retiree Dental Program under Title 10 USC 1076c.

Root Canal Therapy (Root Canal)
An endodontic procedure involving the treatment of disease and injuries of the tooth pulp and related periradicular conditions. Commonly called a root canal.

Root Planing
A periodontal procedure that involves the removal of bacteria and mineralized plaque deposits from the root surfaces and tooth pocket. Sometimes called a “deep cleaning.”

Sealant
A composite material, usually a plastic coating, that is bonded to the biting surface of teeth to seal decay-prone pits, fissures, and grooves of teeth to prevent decay.

Service Area
The area in which enrollees may obtain dental treatment that is covered under the TRDR. The service area for the Enhanced TRDP 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. Enrollees in the Enhanced TRDP are eligible only for emergency care outside this service area; however, worldwide coverage for the full scope of benefits is available for Enhanced TRDP enrollees who reside outside this area.

Submitted Amount
The amount normally charged by the dentist for services provided to all patients, regardless of insurance coverage.

Subscriber
The retired member or deceased member of one of the seven Uniformed Services whose relationship to their spouse or child determines their eligibility for the TRICARE Retiree Dental Program.

Subscriber Identification Number
Either the subscriber’s social security number or Department of Defense Benefits Number, used by Delta Dental to identify the subscriber and/or family members enrolled in the TRDP.

Temporary Crown
A restorative procedure that involves a pre-fabricated resin or stainless steel tooth covering (cap) that is placed over a tooth. A temporary crown is included in the fee for cast restorations.

TRICARE Dental Program (TDP)
The dental plan offered by the Department of Defense through the Defense Health Agency (DHA) to family members of all active duty service members of the Uniformed Services and to National Guard/Reserve members and/or their families. The TDP is administered by MetLife.

TRICARE Retiree Dental Program (TRDP)
Universal/National Tooth Numbering System
A system that assigns a unique number (from 1-32) to permanent teeth, and a unique letter (A-T) for primary teeth.

Uniformed Services
The Army, Navy, Air Force, Marine Corps, Coast Guard, the National Oceanic and Atmospheric Administration and the Commissioned Corps of the U.S. Public Health Service and their Reserve/Guard components.

Unremarried Surviving Spouse
The unremarried spouse of a deceased Uniformed Services member.

Waiting Period
The specific period of time of continuous enrollment (i.e., 12 months) that an enrollee in the TRDP must complete before applicable dental procedures become covered benefits.

X-ray
See Radiograph.
Tooth Chart
The following tooth chart illustrates both primary and permanent dentition. Each tooth is identified by letter or number using the Universal/National Tooth Designation System.

Permanent Teeth

**Posterior**
1—3rd molar (wisdom tooth)
2—2nd molar (12-yr. molar)
3—1st molar (6-yr. molar)
4—2nd bicuspid (2nd premolar)
5—1st bicuspid (1st premolar)

**Anterior**
6—cuspid (canine/eye tooth)
7—lateral incisor
8—central incisor