DeltaCare® USA

Individual/Family Dental Program

Disclosure Form/Contract

Provided by:

Alpha Dental Programs, Inc.
700 Parker Square, Suite 150
Flower Mound, Texas 75028
800-422-4234
wekeepyousmiling.com

DISCLOSURE FORM/CONTRACT ("CONTRACT")

This booklet is a Disclosure Form/Contract ("Contract") for your Individual/Family Dental HMO Program ("Program") provided by:

> Alpha Dental Programs, Inc. ("ALPHA") dba DeltaCare USA
> a Single Service Health Maintenance Organization ("HMO")
> 700 Parker Square
> Suite 150
> Flower Mound, Texas 75028
> 800-422-4234

Administrative functions described throughout this booklet may be performed by Delta Dental Insurance Company ("Delta Dental"), a third party administrator, as designated by ALPHA.

The booklet discloses the terms and conditions of the Program available in Texas. **PLEASE READ THE ENTIRE DOCUMENT COMPLETELY AND CAREFULLY.** You have a right to review this Contract prior to enrollment.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIZED SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

ADDITIONAL INFORMATION ABOUT YOUR BENEFITS IS AVAILABLE BY CALLING THE CUSTOMER SERVICE DEPARTMENT AT 800-422-4234, 7 a.m. – 8 p.m. CENTRAL TIME, MONDAY THROUGH FRIDAY. THESE CALLS WILL BE ANSWERED BY ALPHA'S ADMINISTRATOR, DELTA DENTAL INSURANCE COMPANY.

TEXAS NOTICE OF COMPLAINT

IMPORTANT NOTICE

To obtain information or make a complaint, you may call ALPHA's toll-free telephone number at:

800-422-4234

You may also write to ALPHA at:

12898 Towne Center Drive
Cerritos, CA 90703

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your Premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja, usted pueda llamar al numero de telefone gratis de ALPHA al:

800-422-4234

Usted tambien puede escribir a ALPHA:

12898 Towne Center Drive
Cerritos, CA 90703

Puede communicarse con el Departamento de Seguros de Texas para obtener informacion acerca de Companias, coberturas, derechos o guejas al:

800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su Prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces communicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

DeltaCare® USA

Alpha Dental Programs, Inc.
700 Parker Square
Suite 150
Flower Mound, TX 75028

INDIVIDUAL/FAMILY DENTAL HMO PROGRAM ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Check One

❑ New Enrollment ❑ Address Change
❑ Name Change ❑ Add Dependent
❑ Facility Change* ❑ Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

Month ___ Day ___ Year ___

Broker #: ____________

ENROLLMENT SECTION

Please complete Payment Authorization Section

VERY IMPORTANT - PLEASE PRINT LEGIBLY

Your Full Name: ______________________________
Last First MIddle

Mailing Address: ______________________________
Street City State & Zip

Date of Birth: ____________ Male ❑ Female ❑ Home Phone: (_____) __________ Identification #: ______________

Contract Facility name: ______________________________ Contract Facility #: ______________

Dependent Information *Please list all dependents to be covered. If additional space is needed attach a separate sheet.*

Relationship Code*	DEPENDENT NAME (include last name only if different than yours)	BIRTHDATE Mo/Day/Year	SEX	DEPENDENT STATUS	CONTRACT FACILITY	
					Contract Facility #	Facility Name
	SPOUSE		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete		
	CHILD		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete		
	CHILD		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete		

**Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:*

Spouse - SP Domestic Partner - DP Child - CH Other Child - OC

Dental benefits are provided by the Contract Facility selected above. A list of contract dentists is furnished with the Contract or is available at wekeepyousmiling.com. Treatment received from an out-of-network Dentist is not covered except as otherwise described in this Contract.

What is your primary language? ❑ English ____ ❑ Spanish ____ ❑ Other ____________

Do you have a disability affecting your ability to communicate or read which could be accommodated by providing you a Disclosure Form/Contract in a specific format?
If so, what format? ______________________________

TXA46

Enrollment is also available through our web site: wekeepyousmiling.com

PAYMENT AUTHORIZATION SECTION

Please complete Enrollment Section

PROGRAM COST - Annual

Choose one based on the information completed in the Enrollment Section

- ❑ Primary Enrollee Premium **$150.00**
- ❑ Primary Enrollee plus one dependent Premium **$250.00**
- ❑ Primary Enrollee plus two or more dependents Premium **$370.00**
- ☒ One-time Enrollment Fee **$ 15.00**

TOTAL **$_______**

Additional information regarding Program Costs and Payment Options can be found on page 4 & 5 of this booklet.

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective by the first day of the following month.

I wish to enroll in the Individual/Family Dental HMO Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

PAYMENT OPTION (choose only one)

❑ **CHECK/MONEY ORDER PAYMENT OPTION**

Please make check or money order payable to ALPHA. You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of Benefits.

❑ **CREDIT CARD PAYMENT OPTION**

❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

CARD # ______________________________

EXPIRATION DATE ______________________________

NAME AS IT APPEARS ON THE CARD

____

SIGNATURE ______________________________

DATE ______________________________

By signing above you authorize ALPHA to charge your credit card account for the cost of the Program. This authority shall remain in effect to renew your annual enrollment unless you give written notification of termination 30 days prior to the expiration of the contract term.

Note: Any credit card refunds under the Program may be made by check or credit card.

I understand that, if I have indicated on this form that coverage under the Program is to be provided only for the dependent child(ren) named above, I am responsible for payment of the required annual Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

Have you selected a Contract Dentist? If not, we will assign you to a facility near your home.

______________________________ Signature of Applicant

______________________________ Date

TXA46

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Definitions

As used in this Contract:

Administrator means Delta Dental Insurance Company ("Delta Dental"), licensed as a Third Party Administrator in the State of Texas. Administrative functions described in the Contract and in this booklet may be performed by Delta Dental, as designated by ALPHA. The mailing address for Delta Dental is 12898 Towne Center Drive, Cerritos, California 90703. Delta Dental will answer calls directed to (800) 422-4234.

Applicant means the individual contracting to obtain dental Benefits as the primary Enrollee. YOU or YOUR refers to the Applicant.

Benefits mean those dental services which are provided under the terms of this Contract and described in this booklet.

Contract means this agreement between ALPHA and the Applicant including the *Enrollment and Payment Authorization Form*, the attached schedules, and any appendices, endorsements or riders. This Contract constitutes the entire agreement between the parties.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialty Care Dentist means a Dentist who provides Specialized Services, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Term means the one-year period starting on the Effective Date and each annual renewal period during which the Contract remains in effect.

Copayment means the amounts charged to an Enrollee by a Contract Dentist or Contract Specialty Care Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Domestic Partner means a person who has, together with the primary Enrollee, affirmed a domestic partnership through an affidavit of domestic partnership provided to ALPHA.

Effective Date means the first day of the month following ALPHA's timely receipt of Premium and the *Enrollment and Payment Authorization Form*.

Eligible Dependent means any dependent of a primary Enrollee who is eligible for Benefits as described in this booklet.

Emergency Dental Services means procedures administered in a Dentist's facility, emergency dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

Enrollee means a person enrolled to receive Benefits including the primary Enrollee and Eligible Dependent(s).

Preauthorization means the process by which ALPHA determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Premium means the amount payable as provided in this Contract. Refer to page 4, *How much do I pay?*

Service Area means the State of Texas, **except** for the following counties:

> Armstrong, Bailey, Bowie, Brewster, Briscoe, Brown, Carson, Castro, Cochran, Coke, Coleman, Collingsworth, Concho, Crosby, Culberson, Dallam, Deaf Smith, Donely, Edwards, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchison, Jasper, Jeff Davis, Kinney, Lamb, Lipscomb, Loving, Lubbock, McCullough, Menard, Moore, Motley, Newton, Ochiltree, Oldham, Parmer, Pecos, Potter, Presidio, Randall, Reeves, Roberts, Runnels, Sabine, San Augustine, Schleicher, Shelby, Sherman, Sutton, Swisher, Terrell, Tom Green, Val Verde, Wheeler, and Willacy.

Specialized Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry.

Usual Fee means the fee that an individual Dentist most frequently charges for a given dental service.

We, Us or Our means ALPHA or its Administrator, Delta Dental, as appropriate.

What is the Individual/Family Dental Program ("Program")?

The Individual/Family Dental HMO Program ("Program") provides comprehensive dental care through a convenient network of Contract Dentists in the State of Texas. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

How to use the Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist from the list of dental facilities furnished with this Contract. You must indicate the Contract Dentist's name and facility ID # on the *Enrollment and Payment Authorization Form*. YOU MAY OBTAIN TREATMENT FROM ANY CONTRACT DENTIST AT THAT FACILITY.

Shortly after enrollment, you will receive a membership packet which advises you of the Effective Date of your coverage. The packet will also show the address and telephone number of your Contract Dentist. You may obtain covered dental services any time after your Effective Date. To make an appointment, simply call your Contract Dentist's facility and identify yourself as an Enrollee in this Program. Your assigned Contract Dentist also maintains a 24-hour Emergency Dental Services system seven days a week. Initial appointments should be scheduled within three weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Contract Dentists should be directed to the Customer Service department at (800) 422-4234.

EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN BENEFITS EXCEPT FOR SERVICES PROVIDED BY A CONTRACT SPECIALTY CARE DENTIST OR FOR EMERGENCY DENTAL SERVICES. (REFER TO *SCHEDULE A*.) ANY OTHER TREATMENT PROVIDED BY AN OUT-OF-NETWORK DENTIST (UNLESS EXPRESSLY AUTHORIZED BY ALPHA) IS NOT COVERED UNDER THIS PROGRAM.

Who is eligible for coverage?

You, and your Eligible Dependents, as defined below, are eligible. You and your Eligible Dependents become eligible:

1) on the first day of the month following our receipt of timely Premium and complete enrollment information;
2) as soon as they become your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Your Eligible Dependents include:

1) spouse (unless legally separated or divorced) or Domestic Partner (until such partnership is terminated by either or both parties);
2) unmarried children and grandchildren from birth up to age 25 provided they are chiefly dependent on you for support.

Children include natural children, stepchildren, adopted children, foster children, grandchildren and children of a Domestic Partner if they are dependent on you for support. Grandchildren must live with you to be eligible. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notification of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Foster children are eligible from and after the moment they are placed in your physical custody. Adopted children (other than newborns) are eligible from and after the moment you file suit for adoption. Dependents in military service are not eligible.

An unmarried child over the age of 25 may remain eligible if that child is incapable of self-support because of a physical disability or mental incapacity and is chiefly dependent on you for support and maintenance. See *Renewal, Cancellation and Termination of Benefits*.

To be eligible, you must live or work in ALPHA's Service Area and the permanent legal residence of any enrolled dependent must be the same as yours. If any of your enrolled dependents do not live with you, they must reside in ALPHA's Service Area in order to maintain eligibility (except as described in #4 below).

If the legal residence of any enrolled dependent is not the same as yours, the dependent's legal address must be:

1) in ALPHA's Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where you have legal responsibility for the health care of such dependents; or
2) in ALPHA's Service Area under other circumstances where you are legally responsible for the health care of such dependents; or
3) in ALPHA's Service Area with your spouse or Domestic Partner; or
4) anywhere in the United States for a child whose coverage under the Program is required by a medical support order.

How do I enroll?

First, please read all the information contained in this Contract (particularly the *Schedule of Benefits and Copayments, Limitations and Exclusions*). This way you will know what procedures are covered and what your Copayments and Premium will be. Second, from the network directory, choose a dental facility that is convenient for you and your family's treatment. Third, complete the *Enrollment and Payment Authorization Form* and indicate which contract facilities you have chosen.

How much do I pay?

The annual Premium for the initial Contract Term is:

*	Primary Enrollee only (one person): *plus a one time enrollment fee of $15.00*	$150.00
*	Primary Enrollee and one dependent (spouse or child): *plus a one time enrollment fee of $15.00*	$250.00
*	Primary Enrollee and two or more dependents: *plus a one time enrollment fee of $15.00*	$370.00

A full refund of Premium, including the one-time enrollment fee, is available if the written request for refund is made within the first month of the Contract Term. Thereafter, requests for Premium refund will be pro-rated based upon the number of months remaining in the Contract Term subject to the following conditions:

1) The one-time enrollment fee is not refundable after the first month of coverage;
2) You have not received any Benefits under the Program;

3) There is at least one month remaining in the Contract Term;
4) Coverage is based on a full calendar month. There are no partial month refunds.

Choose a Payment Option

ALPHA gives you two easy payment options. Your annual Premium may be charged to your MasterCard, Visa, Discover or American Express account. Or, you may pay by personal check or money order. Be sure to indicate which payment option you have chosen.

* **Credit Card Payment Option**
  Under this option, your annual Premium and the $15.00 one-time enrollment fee will be charged to your MasterCard, Visa, Discover or American Express account.

* **Check/Money Order Payment Option**
  If you choose this option, make your check payable to ALPHA. Checks returned for insufficient funds are subject to a $25.00 processing fee which must be paid before coverage will be reinstated.

Mailing Instructions

Please mail the completed *Enrollment and Payment Authorization Form* with either credit card information or a check or money order for the Premium and the $15.00 enrollment fee to:

Alpha Dental Programs, Inc.
c/o Delta Dental Insurance Company
Dept. 0170
Los Angeles, CA 90084-0170

What will my Effective Date be?

We must receive the enrollment materials by the 21st day of the month for coverage to start the first day of the following month. If we receive the enrollment materials after the 21st day of the month, coverage will begin the first day of the second month.

Emergency Dental Services

Your assigned Contract Dentist maintains a 24-hour Emergency Dental Services system seven days a week. The Contract Dentist will provide Emergency Dental Services for covered procedures whenever possible. If you require Emergency Dental Services and are unable to access care from your Contract Dentist, then we will reimburse you for the cost of such Emergency Dental Services which exceeds your Copayment. Emergency Dental Services will be limited to listed procedures, and as described in code D9110 "Palliative (emergency) treatment of dental pain." Any further treatment of the cause of such Emergency Dental Services must be obtained from the Contract Dentist. (Refer to *Schedule A*.) You will be responsible for the Copayment(s).

Specialized Services

Specialized Services for oral surgery, endodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist. You will pay for all Specialized Services, which are Benefits provided by a Contract Specialty Care Dentist, directly to the Contract Specialty Care Dentist. (Refer to *Schedule A*.)

IF YOU REQUIRE SPECIALIZED SERVICES AND THERE IS NO CONTRACT SPECIALTY CARE DENTIST TO PROVIDE THESE SERVICES WITHIN 35 MILES OF YOUR HOME ADDRESS, YOUR ASSIGNED CONTRACT DENTIST MUST RECEIVE AUTHORIZATION FROM US TO REFER YOU TO AN OUT-OF-NETWORK DENTIST TO PROVIDE THE SPECIALIZED SERVICES. SPECIALIZED SERVICES PERFORMED BY AN OUT-OF-NETWORK DENTIST THAT ARE NOT AUTHORIZED ARE NOT COVERED.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in *Schedule A, Description of Benefits and Copayments* and *Schedule B, Limitations and Exclusions* to determine Benefits.

What if I need to change Contract Dentists?

You may change your assigned Contract Dentist by directing a request to the Customer Service department or by visiting our web site at (wekeepyousmiling.com). In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, a change in Contract Dentist must be requested before the 21st day of the month to be effective on the first day of the following month. We will provide an Enrollee written notice of assignment to another Contract Dentist facility near the Enrollee's home, if (a) a selected facility is closed to further enrollment, (b) a chosen Contract Dentist withdraws from the Program, or (c) an assigned facility requests, for good cause, that the Enrollee be reassigned to another Contract Dentist.

All treatment in progress must be completed before you change to another Contract Dentist. For example, this would include (a) partial or full dentures for which final impressions have been taken, (b) completion of root canals in progress and (c) delivery of crowns when teeth have been prepared.

If your assigned Contract Dentist terminates participation in this Program, that Contract Dentist will complete all treatment in progress as described above.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in *Schedule A* subject to the limitations and exclusions described in *Schedule B*. Benefits are only available in the State of Texas. The services are performed as deemed appropriate by your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A*. Copayments are paid directly to the Dentist who provides treatment. In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for provisions in *Emergency Dental Services* (unless otherwise expressly authorized by us), we will not pay a Dentist who is not a Contract Dentist, therefore, if you have received unauthorized treatment from an out-of-network Dentist, you will be liable to that Dentist for the cost of services. For further clarification, see *Emergency Dental Services* and *Specialized Services*.

Claims for Reimbursement

Claims for covered Emergency Dental Services should be sent to us within 90 days of the end of treatment. Valid claims will be reviewed after 90 days if you can show that it was not reasonably possible to submit the claim within that time. Late claims must be submitted as soon as possible. All claims must be received within one year of the treatment date.

We will acknowledge receipt of Enrollee claims in writing and initiate investigation of claims within 15 days. You will be requested to provide additional information, if required.

Claims submitted with all necessary information will be accepted or rejected within 15 business days of receipt. Notice of rejected claims will state the reason for the rejection. In the event additional information is required and a determination cannot be made, you will receive written notification within this 15-day period stating the reason for the delay.

All claims will be accepted or rejected within 45 days of that notice. Accepted claims will be paid not later than the fifth business day following notice of acceptance. If payment is subject to performance of an act by the Enrollee, the claim will be paid not later than the fifth business day after the date the act is performed.

Enrollee Complaint Procedure

A complaint means any written or oral dissatisfaction about any aspect of our operation including, but not limited to, dissatisfaction with our administration; procedures; denial, reduction or termination of services for reasons **not related to medical necessity**; disenrollment decisions or the quality of dental services performed by a Contract Dentist. You may call the Customer Service department at (800) 422-4234 or write:

Quality Management Department
c/o Delta Dental
12898 Towne Center Drive
MS: QM600
Cerritos, CA 90703-8579

If you write, you must include 1) the name of the patient, 2) the name, address, telephone number and identification number (i.e. Social Security number) of the primary Enrollee, and 3) the Dentist's name and address.

A complaint does **not** include a misunderstanding or problem of misinformation which can be promptly resolved by supplying correct information to your satisfaction.

We do not make determinations about the medical necessity of dental services and only determine if services are covered Benefits under this Contract. We will provide notification if any dental services are not covered Benefits, stating the specific Contract provision(s).

Within five business days after receipt of an oral or written complaint, the quality management coordinator will send a letter acknowledging the date of receipt of the complaint, a description of our complaint procedures, estimated time frames for resolution of complaints and a request for any necessary information. If the complaint was received orally, the acknowledgement will include a one-page complaint form with instructions to return for prompt resolution of the complaint. **Processing of the complaint will generally not begin until we receive the information shown above. However, we will respond to complaints involving Emergency Dental Services within 24 hours after receipt of the complaint.**

The complainant may call the Customer Service department at (800) 422-4234 at any time between 7 a.m. and 8:00 p.m., Central Time, to discuss the complaint. Those complaints requiring professional expertise shall be referred to a licensed dental consultant or the dental director for review. Certain complaints may also require a second opinion for a clinical evaluation of the dental services provided. Second opinions will be provided at another Contract Dentist's facility unless otherwise authorized by ALPHA's dental consultant. We will only pay for a second opinion which we have authorized.

We will resolve a complaint involving Emergency Dental Services within 24 hours after our receipt. Complaints that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the complainant a written report which describes the complaint and our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the complainant of:
1) the specialization of any Dentist or other provider consulted;
2) a description of our appeal procedure; and
3) the time frames for our appeal process and final decision.

In the event a complainant is not satisfied with our resolution of a complaint, he/she will have the right to appeal the decision before a complaint appeal panel. Within five business days after receipt of a request for an appeal, we will send a letter acknowledging the date of receipt of the request and include a statement of the complainant's rights to:
1) appear before an appeal panel in person (or through a representative if a minor or disabled) in the area where the Enrollee received the care or at an agreed upon location; or
2) write to an appeal panel;
3) to present alternative expert testimony;
4) to present oral or written information; and
5) to question those responsible for the prior resolution.

Our appeal panel is composed of Enrollee representatives, Contract Dentist representatives and ALPHA representatives in equal numbers. Contract Dentists

cannot review a case in which they rendered care or a case they reviewed during our complaint or appeal process. The panel will include a Contract Specialty Care Dentist if the quality of specialty care is at issue. Our employees cannot serve as Enrollee members.

No later than five business days before the scheduled meeting of the appeal panel, unless the complainant agrees otherwise, we shall provide to the complainant or the complainant's designated representative:

1) any documentation to be presented to the panel by us;
2) the specialization of any providers consulted during the investigation of the appeal; and
3) the name and affiliation of each ALPHA representative on the panel.

We will send a written resolution of the appeal within 30 calendar days after receipt of an appeal. Investigation and resolution of appeals involving ongoing Emergency Dental Services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for appeal. At the request of the Enrollee, we will provide, instead of an appeal panel, a provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal. The provider reviewing the appeal may interview the Enrollee or the Enrollee's designated representative and will make a decision on the appeal. Initial notice of decision of the appeal may be delivered orally, but will be followed by a written notice of the determination within three days.

Notice of our final decision will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

Any Enrollee, including an Enrollee who has attempted to resolve a complaint through the complaint process described above, may file a complaint with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091. The Department's toll-free telephone number is (800) 252-3439.

The commissioner will investigate a complaint against us to determine our compliance with the insurance laws within 60 days after the Department receives the complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1) additional information is needed;
2) an on-site review is necessary;
3) we, the provider, or the complainant do not provide all documentation necessary to complete the investigation; or
4) other circumstances beyond the control of the Department occur.

We will not engage in any retaliatory action (including termination or refusal to renew a Contract) against an Enrollee, or a Dentist (on behalf of an Enrollee) for filing a complaint or appealing a decision.

Renewal, Cancellation and Termination of Benefits

No change in Benefits or Premium will be made during a Contract Term. We will send you a written renewal notice, including any proposed changes in Benefits and/or Premium at least 60 days before your coverage expires. Your coverage will terminate at the end of the Contract Term unless you renew by paying the applicable Premium on or before the expiration date of your Contract.

Receipt of the applicable Premium by us after termination of your coverage will reinstate your coverage unless payment is received more than 15 days after termination and we refund such payment within 20 business days.

We will cancel enrollment in the following events:

1) For any Eligible Dependent, immediately upon receipt of a written notice regarding the loss of dependent status; however, an unmarried dependent child may continue eligibility if:
   a) he or she is incapable of self-support because of a physical or mental incapacity that began prior to reaching the limiting age;
   b) he or she is chiefly dependent on you for support; and
   c) proof of dependent's disability or incapacity is provided within 31 days of request by ALPHA and subsequently as required. Such requests will not be made more than once a year after the Eligible Dependent reaches age 25;
2) Immediately, if the Enrollee is guilty of misconduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
3) Upon 15 days written notice if the Enrollee knowingly perpetrates or permits another person to perpetrate fraud or deception in obtaining Benefits;
4) Upon 30 days written notice if the Enrollee or dependent Enrollee neither resides, lives or works in ALPHA's Service Area. However, coverage for a child who is the subject of a medical support order cannot be cancelled solely because the child does not reside, live or work in ALPHA's Service Area;
5) Upon 30 days written notice if the Enrollee fails to pay Copayments; provided, however, that the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges;
6) Upon 30 days written notice upon failure of an Enrollee and a Contract Dentist to establish a satisfactory patient-dentist relationship. ALPHA must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. In addition, ALPHA must provide 30 days advance, written notice that ALPHA considers the patient-dentist relationship to be unsatisfactory and must specify the changes that are necessary in order to avoid cancellation. Coverage will be cancelled if the Enrollee fails to make such changes;
7) Upon 90 days written notice if ALPHA discontinues coverage of this Individual/Family Dental HMO Program uniformly without regard to health status related factors of Enrollees.

Coverage for an Enrollee will terminate as of the date enrollment is cancelled under the terms of this Contract. However, we will continue to provide Benefits for completion of any treatment in progress (less any applicable Copayment).

Cancellation of a primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her dependent Enrollees. Any cancellation is subject to the notification requirements set forth in this booklet.

Grace Period

A grace period of 30 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Contract will continue in force. If your coverage terminates for non-payment, you will be responsible for the cost of services rendered during that grace period.

Reinstatement

If any renewal Premium is not paid within the time granted the primary Enrollee for payment, a subsequent acceptance of Premium by us without also requiring an application for reinstatement, shall reinstate the Contract. However, if ALPHA requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Contract will be reinstated upon approval of such application by us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless we have previously notified the Applicant in writing of our disapproval of such application.

The reinstated Contract shall cover only loss due to sickness that begins more than ten days after such date. In all other respects the Enrollee and ALPHA shall have the same rights thereunder as they had under the Contract immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Coverage Continuation

An Enrollee who loses coverage under this Program due to a change in marital status and who continues to reside in the Service Area will have the right to convert to his or her own individual coverage within 31 days of loss of coverage under this Program without presenting evidence of insurability. A person electing to convert to his or her own individual coverage must pay Premium to us at individual rates established by us. However, no conversion right will be offered to any person who ceases to be covered because this Program is terminated or because that person's enrollment was cancelled for any of the reasons described in subparagraph 2 under *Renewal, Cancellation and Termination of Benefits*.

Entire Contract

This Contract, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement governing the Program. No amendment is valid unless approved by an executive officer of ALPHA and attached to this booklet. No agent or broker has authority to amend this Contract or waive any of its provisions.

Conformity With State Statutes

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the State of Texas is hereby amended to conform to the minimum requirements of such statutes.

ALPHA shall comply in all respects with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information. ALPHA agrees that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplification, security or privacy laws or regulations.

Incontestability

In the absence of fraud or intentional misrepresentation made by you in the enrollment application, all statements made in that application are representations and not warranties. The statements are considered to be truthful and are made to the best of your knowledge and belief. A statement may not be used to void, cancel or non-renew your coverage or reduce Benefits unless (i) it is in a written enrollment application signed by you, and (ii) a signed copy of the enrollment application is or has been furnished to you or your personal representative.

Right to Examine Contract

Within ten days from the date of purchase if you are not satisfied for any reason with the coverage as described in this Contract, you may write to us and request a full refund of the Premium and the one-time enrollment fee. The notification must be postmarked by the 20th day of the month preceding the Effective Date as determined under the provision entitled *Mailing Instructions*. If you send written notification and return this Contract, it will be considered void from the beginning and no coverage will have been or will be provided. You will be responsible for any services rendered during this ten day period as if no Contract had been issued.

SCHEDULE A
Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2007 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." ****	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months* [1]	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months* [1]	No Cost

Code	Description	Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

**D1000-D1999 II. PREVENTIVE - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." **[1]

Code	Description	Cost
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*[1]	$15.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	$15.00
D1203	Topical application of fluoride (prophylaxis not included) - child - *1 per 6 month period*[1]	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - *child to age 19; 1 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *through age 15*	$10.00
D1510	Space maintainer - fixed - unilateral	$100.00
D1515	Space maintainer - fixed - bilateral	$125.00
D1520	Space maintainer - removable - unilateral	$100.00
D1525	Space maintainer - removable - bilateral	$125.00
D1550	Re-cementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

D2000-D2999 III. RESTORATIVE - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." *

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

Code	Description	Cost
D2140	Amalgam - one surface, primary or permanent	$26.00
D2150	Amalgam - two surfaces, primary or permanent	$36.00
D2160	Amalgam - three surfaces, primary or permanent	$44.00
D2161	Amalgam - four or more surfaces, primary or permanent	$52.00
D2330	Resin-based composite - one surface, anterior (*tooth colored*)	$35.00
D2331	Resin-based composite - two surfaces, anterior (*tooth colored*)	$45.00

Code	Description	Fee
D2332	Resin-based composite - three surfaces, anterior (*tooth colored*)	$55.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (*tooth colored*)	$65.00
D2390	Resin-based composite crown, anterior	$65.00
D2391	Resin-based composite - one surface, posterior (*tooth colored*)	$65.00
D2392	Resin-based composite - two surfaces, posterior (*tooth colored*)	$75.00
D2393	Resin-based composite - three surfaces, posterior (*tooth colored*) [2, 3]	$90.00
D2394	Resin-based composite - four or more surfaces, posterior (*tooth colored*) [2, 3]	$100.00
D2510	Inlay - metallic - one surface [2, 3]	$240.00
D2520	Inlay - metallic - two surfaces [2, 3]	$260.00
D2530	Inlay - metallic - three or more surfaces [2, 3]	$280.00
D2542	Onlay - metallic - two surfaces [2, 3]	$245.00
D2543	Onlay - metallic - three surfaces [3]	$265.00
D2544	Onlay - metallic - four or more surfaces [3]	$285.00
D2610	Inlay - porcelain/ceramic - one surface [3]	$320.00
D2620	Inlay - porcelain/ceramic - two surfaces [3]	$340.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [3]	$355.00
D2642	Onlay - porcelain/ceramic - two surfaces [3]	$355.00
D2643	Onlay - porcelain/ceramic - three surfaces [3]	$375.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [3]	$400.00
D2650	Inlay - resin-based composite - one surface (*tooth colored*) [3]	$210.00
D2651	Inlay - resin-based composite - two surfaces (*tooth colored*) [3]	$250.00
D2652	Inlay - resin-based composite - three or more surfaces (*tooth colored*) [3]	$280.00
D2662	Onlay - resin-based composite - two surfaces (*tooth colored*) [3]	$290.00
D2663	Onlay - resin-based composite - three surfaces (*tooth colored*) [3, 4]	$305.00
D2664	Onlay - resin-based composite - four or more surfaces (*tooth colored*) [3, 4]	$335.00
D2710	Crown - resin-based composite (indirect) [3, 4]	$125.00
D2712	Crown - ¾ resin-based composite (indirect) [3, 4]	$125.00
D2720	Crown - resin with high noble metal [3, 4]	$395.00
D2721	Crown - resin with predominantly base metal [3, 4]	$295.00
D2722	Crown - resin with noble metal [3, 4]	$295.00
D2740	Crown - porcelain/ceramic substrate [3, 4]	$395.00
D2750	Crown - porcelain fused to high noble metal [3, 4]	$395.00
D2751	Crown - porcelain fused to predominantly base metal [3]	$295.00
D2752	Crown - porcelain fused to noble metal [3]	$295.00
D2780	Crown - ¾ cast high noble metal [3]	$395.00

D2781	Crown - ¾ cast predominantly base metal [3]	$295.00
D2782	Crown - ¾ cast noble metal [3]	$295.00
D2790	Crown - full cast high noble metal [3]	$395.00
D2791	Crown - full cast predominantly base metal [3]	$295.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium	$395.00
D2910	Recement inlay, onlay or partial coverage restoration	$15.00
D2915	Recement cast or prefabricated post and core	$15.00
D2920	Recement crown	$15.00
D2930	Prefabricated stainless steel crown - primary tooth	$65.00
D2931	Prefabricated stainless steel crown - permanent tooth	$65.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Sedative filling	$15.00
D2950	Core buildup, including any pins [2]	$50.00
D2951	Pin retention - per tooth, in addition to restoration [2]	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$90.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$50.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$85.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$45.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$20.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$59.00
D2980	Crown repair, by report	$45.00

D3000-D3999 IV. ENDODONTICS - ***When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." ****

D3110	Pulp cap - direct (excluding final restoration)	$18.00
D3120	Pulp cap - indirect (excluding final restoration)	$18.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$30.00
D3221	Pulpal debridement, primary and permanent teeth	$40.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) [5]	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) [5]	$40.00

D3310	*Root canal* - anterior (excluding final restoration) [5]	$150.00
D3320	*Root canal* - bicuspid (excluding final restoration) [5]	$220.00
D3330	*Root canal* - molar (excluding final restoration) [5]	$270.00
D3346	Retreatment of previous root canal therapy - anterior [5]	$170.00
D3347	Retreatment of previous root canal therapy - bicuspid [5]	$240.00
D3348	Retreatment of previous root canal therapy - molar [5]	$290.00
D3410	Apicoectomy/periradicular surgery - anterior [5]	$150.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) [5]	$150.00
D3425	Apicoectomy/periradicular surgery - molar (first root) [5]	$150.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$75.00
D3430	Retrograde filling - per root	$65.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [5]	$65.00

D4000-D4999 V. PERIODONTICS - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." ***

Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$240.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$45.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$240.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$240.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$440.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$440.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$75.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$75.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$75.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period* [6, 7]	$55.00

D5000-D5899 VI. PROSTHODONTICS (removable) [6, 7]

Code	Description	Fee
D5110	Complete denture - maxillary [6, 7]	$350.00
D5120	Complete denture - mandibular [6, 7]	$350.00
D5130	Immediate denture - maxillary [6, 7]	$400.00
D5140	Immediate denture - mandibular [6, 7]	$400.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [6, 7]	$380.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [6, 7]	$380.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [6, 7]	$405.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [6, 7]	$405.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [6]	$455.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [6]	$455.00
D5410	Adjust complete denture - maxillary [6]	$15.00
D5411	Adjust complete denture - mandibular [6]	$15.00
D5421	Adjust partial denture - maxillary	$15.00
D5422	Adjust partial denture - mandibular	$15.00
D5510	Repair broken complete denture base	$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$25.00
D5610	Repair resin denture base	$35.00
D5620	Repair cast framework	$35.00
D5630	Repair or replace broken clasp	$35.00
D5640	Replace broken teeth - per tooth	$35.00
D5650	Add tooth to existing partial denture [8]	$35.00
D5660	Add clasp to existing partial denture [8]	$35.00
D5710	Rebase complete maxillary denture [8]	$100.00
D5711	Rebase complete mandibular denture [8]	$100.00
D5720	Rebase maxillary partial denture [8]	$100.00
D5721	Rebase mandibular partial denture [8]	$100.00
D5730	Reline complete maxillary denture (chairside) [8]	$65.00
D5731	Reline complete mandibular denture (chairside) [8]	$65.00
D5740	Reline maxillary partial denture (chairside) [8]	$65.00
D5741	Reline mandibular partial denture (chairside) [8]	$65.00
D5750	Reline complete maxillary denture (laboratory) [8]	$100.00

D5751	Reline complete mandibular denture (laboratory) [8]	$100.00
D5760	Reline maxillary partial denture (laboratory) [6]	$100.00
D5761	Reline mandibular partial denture (laboratory) [6]	$100.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [6, 8]	$125.00
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [6, 8]	$125.00
D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered [9]

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]) [9]

D6210	Pontic - cast high noble metal [9]	$395.00
D6211	Pontic - cast predominantly base metal [4, 9]	$295.00
D6212	Pontic - cast noble metal [4, 9]	$295.00
D6240	Pontic - porcelain fused to high noble metal [4, 9]	$395.00
D6241	Pontic - porcelain fused to predominantly base metal [4, 9]	$295.00
D6242	Pontic - porcelain fused to noble metal [4, 9]	$295.00
D6245	Pontic - porcelain/ceramic [4, 9]	$395.00
D6250	Pontic - resin with high noble metal [4, 9]	$395.00
D6251	Pontic - resin with predominantly base metal [9]	$295.00
D6252	Pontic - resin with noble metal [9]	$295.00
D6600	Inlay - porcelain/ceramic, two surfaces [2, 9]	$340.00
D6601	Inlay - porcelain/ceramic, three or more surfaces [2, 9]	$355.00
D6602	Inlay - cast high noble metal, two surfaces [9]	$260.00
D6603	Inlay - cast high noble metal, three or more surfaces [9]	$280.00
D6604	Inlay - cast predominantly base metal, two surfaces [9]	$260.00
D6605	Inlay - cast predominantly base metal, three or more surfaces [9]	$280.00
D6606	Inlay - cast noble metal, two surfaces [9]	$260.00
D6607	Inlay - cast noble metal, three or more surfaces [9]	$280.00
D6608	Onlay - porcelain/ceramic, two surfaces [2, 9]	$355.00
D6609	Onlay - porcelain/ceramic, three or more surfaces [2, 9]	$375.00
D6610	Onlay - cast high noble metal, two surfaces [9]	$245.00
D6611	Onlay - cast high noble metal, three or more surfaces [9]	$265.00
D6612	Onlay - cast predominantly base metal, two surfaces [9]	$245.00

Code	Description	Fee
D6613	Onlay - cast predominantly base metal, three or more surfaces [9]	$265.00
D6614	Onlay - cast noble metal, two surfaces [4, 9]	$245.00
D6615	Onlay - cast noble metal, three or more surfaces [4, 9]	$265.00
D6720	Crown - resin with high noble metal [4, 9]	$395.00
D6721	Crown - resin with predominantly base metal [4, 9]	$295.00
D6722	Crown - resin with noble metal [4, 9]	$295.00
D6740	Crown - porcelain/ceramic [4, 9]	$395.00
D6750	Crown - porcelain fused to high noble metal [4, 9]	$395.00
D6751	Crown - porcelain fused to predominantly base metal [9]	$295.00
D6752	Crown - porcelain fused to noble metal [9]	$295.00
D6780	Crown - ¾ cast high noble metal [9]	$395.00
D6781	Crown - ¾ cast predominantly base metal [9]	$295.00
D6782	Crown - ¾ cast noble metal [9]	$295.00
D6790	Crown - full cast high noble metal [9]	$395.00
D6791	Crown - full cast predominantly base metal	$295.00
D6792	Crown - full cast noble metal [9]	$295.00
D6930	Recement fixed partial denture [2]	$25.00
D6940	Stress breaker [2]	$45.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation*	$90.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation* [2]	$85.00
D6973	Core buildup for retainer, including any pins	$50.00
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$50.00
D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$45.00
D6980	Fixed partial denture repair, by report	$50.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

Code	Description	Fee
D7111	Extraction, coronal remnants - deciduous tooth	$25.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$40.00

Code	Description	Copayment
D7220	Removal of impacted tooth - soft tissue	$65.00
D7230	Removal of impacted tooth - partially bony	$90.00
D7240	Removal of impacted tooth - completely bony	$140.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$155.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$90.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$90.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$120.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$90.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$65.00

D8000-D8999 XI. ORTHODONTICS [10]

*** If a Copayment dollar amount is not listed, Enrollee pays 75 percent of the Contract Orthodontist's "filed fees."*

Code	Description	Copayment
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	**
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	**
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including dependent adult children covered from age 19 to 25*	**
D8660	Pre-orthodontic treatment visit - *not to be charged with any other consultation procedure(s)*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)	**
D8999	Unspecified orthodontic procedure, by report - *includes START-UP FEES, (including initial examination, diagnosis, consultation and initial banding)* [12]	$200.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES - *When referable services are provided by a Contract Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

Code	Description	Copayment
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20.00
D9211	Regional block anesthesia	No Cost

D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$25.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees."

As used in this Schedule, "filed fees" mean the fees on file with ALPHA and charged by the Contract Dentist, Contract Specialty Care Dentist or Contract Orthodontist for performing a specific dental service. Questions regarding these fees should be directed to the Customer Service department at (800) 422-4234.

Emergency Dental Services - The Contract Dentist will provide Emergency Dental Services for covered procedures whenever possible. If an Enrollee requires Emergency Dental Services and is unable to access care from the Contract Dentist, then ALPHA shall reimburse the Enrollee for the cost of such Emergency Dental Services which exceeds the Copayment. Emergency Dental Services shall be limited to listed procedures, and as described in code D9110 above: (Palliative (emergency) treatment of dental pain). Any further treatment of the cause of such Emergency Dental Services must be obtained from the Contract Dentist. All services are subject to the limitations and exclusions of the program.

* If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed, referable procedures that are not available in the contract facility or that require a Dentist to provide Specialized Services may be provided by a contracted oral surgeon, endodontist, periodontist or pediatric dentist at 75 percent of the Contract Specialty Care Dentist's "filed fees." Specialized Services are only available upon referral by the assigned Contract Dentist.

FOOTNOTES

[1] *Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

[2] *Base or noble metal is the benefit if the Contract Dentist determines that it will restore the form and function of the tooth. If an inlay, onlay or indirectly fabricated post and core made of high noble metal is elected by the Enrollee, an additional fee up to $100.00 per tooth will be charged for the upgrade.*

[3] *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

[4] *Porcelain and other tooth-colored materials on molars, if elected by the Enrollee, are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

[5] *A benefit for permanent teeth only.*

[6] *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

[7] *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

[8] *Limited to 1 per denture during any 12 consecutive months.*

[9] *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

[10] *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee), and D8680 (Orthodontic retention). Beyond 24 months, an additional monthly fee not to exceed 75 percent of the Contract Orthodontist's "filed fee" applies.*

[11] *In the event orthodontic treatment is not required or is declined by the Enrollee, a fee of $85.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

[12] *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee not to exceed 75 percent of the Contract Orthodontist's "filed fee" applies.*

Sample Office Visits

CODE	DESCRIPTION	ENROLLEE PAYS
Sample visit #1		
D0999	Office Visit	$5.00
D0150	Comprehensive oral exam	No Cost
D0210	X-rays	No Cost
	TOTAL	**$5.00**
Sample visit #2		
D0999	Office Visit (6 mo. check up)	$5.00
D0160	Detailed oral exam	No Cost
D0210	X-rays (if needed)	No Cost
D1120	Prophylaxis - child	$15.00
	TOTAL	**$20.00**
Sample visit #3		
D0999	Office Visit	$5.00
D0160	Detailed oral exam	No Cost
D0210	X-rays	No Cost
D7111	Single tooth extraction	$25.00
D9215	Local anesthetic	No Cost
	TOTAL	**$30.00**
Sample visit #4		
D0999	Office Visit	$5.00
D2140	One surface amalgam filling	$26.00
D2330	One surface resin filling	$35.00
D9215	Local anesthetic	No Cost
	TOTAL	**$66.00**
Sample visit #5		
D0999	Office Visit	$5.00
D0160	Detailed oral exam	No Cost
D2791	Crown - full cast predominantly base metal *(May require build-up at additional cost)*	$295.00
	TOTAL	**$300.00**

SCHEDULE B
Limitations of Benefits

1. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months. Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period. Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. Prophylaxis or periodontal maintenance is limited to one procedure each six month period. Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.
5. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
6. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling. Replacement of an existing crown, inlay or onlay that is non-functional or non-restorable is a benefit when the existing restoration is five+ years old.
7. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
8. A covered metallic inlay, onlay, and indirectly fabricated post and core using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
9. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
10. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
11. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth with pathology.

12. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
13. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
14. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
15. Coverage for the placement of a fixed partial denture ("bridge") is limited to:
    a. The initial placement of a bridge when all the following conditions are present:
        - a single permanent tooth requires prosthetic replacement.
        - the abutment teeth can adequately support and retain a new bridge.
        - the missing tooth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture.
        - no other missing teeth in the same arch require prosthetic replacement with a new removable partial denture; and (*for a bridge replacing a posterior tooth*) one or more of the abutment teeth meet Limitation #6.
    b. The replacement of an existing bridge that is not serviceable due to decay, fracture or other non-cosmetic defect, if:
        - the existing bridge is at least five years old; **and**
        - the same abutment teeth can adequately support and retain a new bridge; **and**
        - no other missing teeth in the same arch require prosthetic replacement.
16. Coverage for a new removable partial or complete denture is limited to:
    a. The initial placement of removable partial or complete denture in an arch when:
        - one or more permanent teeth require prosthetic replacement; **and**
        - the missing tooth/teeth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture; **and**
        - (for partial dentures only) there are suitable abutment teeth to retain and support a removable partial denture.
    b. The replacement of an existing removable partial or complete denture with non-cosmetic defect(s) that cause the denture to be non-serviceable if:
        - the existing removable denture is at least five years old; **and**
        - the existing removable denture cannot be made serviceable by adjustment, repair, relining or rebasing.
17. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
18. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
        - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**

- The replacement of permanent tooth/teeth for children under 16 years of age.

19. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
20. Retained primary teeth shall be covered as primary teeth.
21. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
22. Benefits provided by a contracted pediatric Dentist are available at 75 percent of the Contract Specialty Care Dentist's "filed fees." Referral by the assigned Contract Dentist is required before services are received.
23. Soft tissue management programs include, but are not limited to, periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for covered services.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of ten or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under this program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered benefits. This exclusion does not eliminate the benefit for other covered services.
8. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
9. Extraction/removal of an erupted, partially erupted or impacted tooth:
    a. Solely for orthodontic purposes.
    b. When the tooth exhibits no signs or symptoms of infection, cystic degeneration, fracture, caries and/or having caused damage to an adjacent tooth; **or**
    c. When the extraction or removal would be inconsistent with generally accepted professional standards.
    d. other extraction/tooth removals that are diagnosed by the attending Dentist as not medically necessary.
10. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
11. Consultations for non-covered benefits.

12. Replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or better match bleached teeth.
13. Dental services received from any dental facility other than the assigned Contract Dentist, including the services of an out-of-network dentist who provides Specialized Services, unless expressly authorized by ALPHA or as cited under *Emergency Dental Services*. To obtain authorization, you should call the Customer Service department at (800) 422-4234.
14. Any procedure that in the professional opinion of the Contract Dentist:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.
15. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
16. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
17. Dispensing of drugs not normally utilized in the delivery of dental services.
18. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with this program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics.
19. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
20. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services that are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.
21. Treatment required by reason of war declared or undeclared.
22. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
23. Charges by the Contract Dentist for broken or missed appointments not reported within 24 hours.
24. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Orthodontic Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. Start-up fees, retention fees, and the cost to the Enrollee for the treatment plan are listed in *Schedule A*, and are subject to the following:

1. Orthodontic treatment must be provided by the selected Contract Orthodontist.
2. Orthodontic Copayments are listed on *Schedule A*, for comprehensive orthodontic treatment. Additional fees will be charged for start-up and retention.
3. Benefits cover 24 months of active comprehensive orthodontic treatment, including initial banding, de-banding and any commonly used appliances such as headgear.
4. Following benefited comprehensive orthodontic treatment, retention is covered up to a maximum of 24 months. Retention includes the initial construction, placement and adjustment to removable retainers and office visits.
5. Treatment plans extending beyond 24 months of active comprehensive orthodontic treatment, or 24 months of retention, will be subject to a monthly office visit fee to the Enrollee not to exceed 75 percent of the Contract Orthodontist's "filed fees" per month.
6. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall increase to a maximum of the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.
7. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $85.00 in addition to diagnostic record fees.
8. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee.
9. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

    a. will not be entitled to a refund of any amounts previously paid; **and**
    b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

10. Coverage and treatment under this Program are conditioned on patients following the treatment plan recommended by their Contract Orthodontist. Failure to follow the instructions of the Orthodontist can compromise the health of teeth and/or gums, which may necessitate discontinuation of treatment. Patients who are required to restart their orthodontic treatment because of non-compliance with the treatment plan will be subject again to all applicable Copayments.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records that include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.
4. Surgical procedures incidental to orthodontic treatment.
5. Myofunctional therapy.
6. Surgical procedures related to cleft palate, micrognathia or macrognathia.
7. Treatment related to temporomandibular joint disturbances.
8. Supplemental appliances not routinely used in comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.
9. Cosmetic care as a result of orthodontic treatment.
10. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
11. Extractions solely for the purpose of orthodontics.
12. Treatment in progress at inception of eligibility.
13. Patient initiated transfer after bands have been placed.
14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

Glossary

The following dental terms have the meanings indicated:

Abrasion - The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

Alveoloplasty - A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

Amalgam - A metal alloy used in filling teeth.

Apicoectomy - The surgical removal of the root tip.

Appliance - A device used to provide function or therapeutic effect.

Attrition - The normal loss of tooth substance resulting from friction during chewing.

Banding - Application of preformed stainless steel rings that are fitted around the teeth and cemented in place.

Banding dentition - Treatment of a tooth which involves banding (for orthodontic purposes).

Cephalometric x-rays - X-rays used in studying the measurements of the head in relation to specific soft tissue and bony reference points.

Cleft palate - A birth defect resulting in an incomplete closure or formation of the palate.

Debridement - The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

Equilibration - Changing the occlusal forms of the teeth by selective grinding, with the interest of balancing occlusal stresses more evenly on the teeth.

Erosion - Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

Exostosis - An excessive growth of bone.

Expansion appliance - An appliance used to widen a dental arch to increase the room available for permanent teeth and/or to correct the bite.

Frenum - The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

Frenectomy - Surgical removal or loosening of the frenum.

Functional appliance - An appliance used to achieve minor tooth movement, to strengthen the muscles of the oral cavity or to maintain space created by the loss or delayed eruption of the teeth.

Gingiva - The soft tissue which covers a tooth or the gum surrounding a tooth.

Gingivectomy - The surgical removal of the unsupported gingiva to the level where it is attached.

Gingivoplasty - Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

Headgear - An apparatus encircling the head or neck that provides attachment for an intraoral appliance in use of extraoral anchorage.

Implant - A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

Lingual - Pertaining to the tongue.

Macrognathia - A definite overgrowth of the mandible and maxilla.

Mandible - The lower jaw.

Mandibular - Pertaining to the lower jaw.

Maxilla - The upper jaw.

Maxillary - Pertaining to the upper jaw.

Micrognathia - An abnormal smallness of the jaws, especially the mandible.

Myofunctional therapy - Training to curb or eliminate abnormal muscle function of the oral cavity.

Occlusal - The chewing surfaces of the posterior teeth.

Occlusion - The contact between the upper and lower teeth when in a closed position.

Orthodontic appliance - Any appliance used to apply forces for tooth movement during orthodontic treatment.

Palate - The roof of the mouth.

Palatal - Pertaining to the roof of the mouth.

Palliative - Action that relieves pain but does not cure the cause of the pain.

Panoramic film - An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

Pediatric or **Pedodontic** - Pertaining to children.

Periapical - The area surrounding or enclosing the root tip of a tooth.

Periodontitis - Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

Periradicular - Around the root.

Pontic - The term used for the artificial tooth on a bridge.

Prophylaxis - The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

Pulp cap - The covering of an exposed dental nerve with material that protects it from foreign irritants.

Quadrant - One of the four equal sections into which the dental arches can be divided; begins at the middle of the arch and goes to the last tooth on either side.

Rebase - Process of refitting a denture by replacing the acrylic base material.

Resin - Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.

Retainer - An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

Retrograde filling - A method of sealing the root canal by preparing and filling it from the root tip.

Root planing - A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as "deep cleaning."

Sealant - Application of a resin material to the biting surfaces of the permanent molars to seal the surface crevices to prevent the formation of decay.

Study model - A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

Supernumerary - Any tooth in excess of the 32 normal permanent teeth.

Temporomandibular joint - The joint formed by the connection of the lower jaw to the skull.

Tracing - As it relates to orthodontic treatment, a tracing is a line drawing of pertinent features of a cephalometric x-ray made on a piece of transparent paper placed over an x-ray. The tracing provides measurements of soft tissue and bony reference points that aid in predicting growth patterns and orthodontic diagnosis and treatment planning.

Trigeminal nerve - The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

Vertical demension - The vertical height of the face with teeth in occulusion.

If you have any questions or need additional information call:

Toll Free
800-422-4234

or write the Program Administrator at:

Delta Dental Insurance Company
12898 Towne Center Drive
Cerritos, CA 90703-8579

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