DELTA DENTAL®

Delta Dental Individual

Delta Dental PPO™
Pediatric Basic Plan

A smart choice for dental coverage.

What is Delta Dental PPO?

Delta Dental PPO is a coinsurance plan that shares your costs for covered dental services. After you meet your annual deductible, Delta Dental pays a percentage of your bill and you pay the rest. Simple!

With this plan, you can visit any dentist, but you'll save the most with a Delta Dental PPO dentist. Why? Because our in-network dentists accept reduced fees for plan enrollees.

Check out the highlights on page 3 to find out what services are covered and what your share would be. Want more? View the full plan design, plus limitations and exclusions.

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Claims and Correspondence
P.O. Box 1809
Alpharetta, GA 30023

Customer Service
888-857-0314
deltadentalins.com

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Is a Delta Dental PPO plan right for me?

Delta Dental PPO could be a smart choice if you like to have plenty of options. Because Delta Dental has one of the largest networks in the country, you have lots of dentists to choose from who can save you money.[1]

You can use our Find a Dentist tool to find a Delta Dental dentist near you. Too many choices? The included Yelp ratings may help you decide.

Delta Dental PPO plans are built around your oral health. That's why we focus on coverage for important preventive services like dental exams and routine cleanings.

Get the care you need with the dentist you choose, and let Delta Dental handle the rest.

Questions?

888-857-0314 deltadentalins.com

This benefit information is only a summary and is not intended to replace or serve as the plan Policy. Please consult the plan Policy for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the plan Policy, the terms of the Policy will prevail.

[1] NetMinder Dental Network Trend Report, March 2020. Based on total unique dentists nationwide.

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HCR_PPO #111750 (3/18)

Attachment A
Deductibles, Maximums, Contract Benefit Levels and Enrollee Coinsurances

Deductibles & Maximums	
Annual Deductible Pediatric Enrollee	A single combined medical and dental deductible applies to both the dental and medical benefits. Please refer to schedule of benefits to determine deductible amount.
Out-of-Pocket Maximum	Please refer to your Schedule of Benefits to determine Out-of-Pocket Maximum amount

Out-of-Pocket Maximum applies only to dental benefits that are provided by PPO Providers for Pediatric Enrollees. Once the amount paid by the Pediatric Enrollee(s) equals the Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services received from PPO Providers. Enrollee Coinsurance and other cost-sharing will continue to apply for covered services from Premier or Out-of-Network Providers, even after the Out-of-Pocket Maximum is met.

If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from PPO Providers is not more than the family Out-of-Pocket Maximum amount, as set forth in the Schedule of Benefits. However, once a Pediatric Enrollee meets the individual Out-of-Pocket Maximum amount for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied their Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from PPO Providers until the total amount paid reaches the family Out-of-Pocket Maximum amount.

Contract Benefit Levels & Enrollee Coinsurances After Deductible		
Dental Service Category	**PPO**[1]	
	PPO Dental plan[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%
Basic Services	100%	0%
Major Services	100%	0%
Medically Necessary Orthodontic Services (requires prior authorization)	100%	0%
Waiting Periods	No Waiting Periods	

[1]Reimbursement is based on PPO Contracted Fees for PPO, Premier and Out-of-Network Providers. Member responsibility can be higher when visiting a Premier or Out-of-Network Provider. Out-of-Network dentist costs will likely include balance billing.

[2]The PPO Dental plan will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for covered services. Note: The Dental plan will pay the same Contract Benefit Level for covered services performed by a PPO Provider, Premier Provider and an Out-of-Network Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Out-of-Network Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services

The PPO Dental plan will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for Essential Health Benefits when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of the dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	cleaning, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
(3)	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
(4)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Basic Services**

(1)	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
(2)	Periodontal Cleanings:	periodontal maintenance.
(3)	Palliative:	emergency treatment to relieve pain.
(4)	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1)	Crowns and Onlays/Inlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2)	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
(7)	Night Guards/Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.

- Note on additional Benefits during pregnancy

  When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each calendar year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means the PPO dental plan will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with the PPO Dental plan's standard processing policies. The processing policies may be revised from time to time; therefore, the PPO Dental plan shall use the processing policies that are in effect at the time the claim is processed. The PPO Dental plan may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Exam and cleaning limitations

a) The PPO Dental plan will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period. See note on additional Benefits during pregnancy.
b) A full mouth debridement is allowed once in a lifetime, when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
c) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
d) Caries risk assessments are allowed once in 36 months.
e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(5) Interim caries arresting medicament application is limited to twice per tooth per calendar year.

(6) X-ray limitations:
a) The PPO Dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), the PPO Dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, The PPO Dental plan considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(7) The fee for pulp vitality tests is included in the fee for any definitive treatment performed on the same date.

(8) Topical application of fluoride solutions is limited to twice within a 12-month period.

(9) A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(10) Sealants are limited as follows:
a) once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
b) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

(11) Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.

(12) Specialist Consultations count toward the oral exam frequency.

(13) The PPO Dental plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.

(14) Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

(15) Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

(16) Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an

emergency palliative treatment is made when performed on permanent teeth.

(17) Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(18) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

(19) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(20) Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(21) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

(22) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24- month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.
b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
c) Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
g) When implant procedures are a covered benefit, 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 is covered as a basic benefit and are limited to once in a 24-month period.

(23) Collection and application of autologous blood concentrate product are limited to once every 36 months.

(24) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when The PPO Dental plan determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

(25) Core buildup, including any pins, are covered not more than once in any 60 month period.
(26) Prefabricated post and core, in addition to crown is covered once per tooth every 60 month period.

(27) Resin infiltration of incipient smooth surface lesions is covered once in any 36 month period.

(28) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(29) Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The PPO Dental plan's payment for implant removal is limited to one (1) for each implant within a 60- month period whether provided under the PPO Dental plan or any other dental care plan.

(30) Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.

(31) An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

(32) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(33) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown,Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.

(34) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.

(35) The PPO Dental plan limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36 month period.
c) Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.

(36) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. The PPO Dental plan will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard. Adjustment of an occlusal guard is allowed once in 12-months following six months from initial placement.

(37) Limitations on Orthodontic Services

a) Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
c) The automatic qualifying conditions are:
    i) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    ii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    iii) A crossbite of individual anterior teeth causing destruction of soft tissue,
    iv) Severe traumatic deviation.
d) The following documentation must be submitted with the request for prior authorization of services by the Provider:
    i) ADA 2006 or newer claim form with service code(s) requested;
    ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    iii) Cephalometric radiographic image or panoramic radiographic image;
    iv) HLD score sheet completed and signed by the Orthodontist; and
    v) Treatment plan.
e) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
f) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
g) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
j) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the PPO Dental plan will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
k) Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.
l) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

m) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Exclusions

The PPO Dental plan does not pay Benefits for:

(1) services that are not Essential Health Benefits.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws;services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited 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), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for teeth that are not developmentally mature.

(13) endodontic endosseous implants.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) treatment by someone other than a Provider or a person who by law may work under a Provider’s direct supervision.

(17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(18) dental practice administrative services including, but not limited preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(21) Deductibles and/or any service not covered under the dental plan.

(22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(23) the initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Delta Dental.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(25) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.

(26) missed and/or cancelled appointments.

(27) Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(28) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(29) dental case management motivational interviewing and patient education to improve oral health literacy.

(30) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(31) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(32) diabetes testing.

(33) corticotomy (specialized oral surgery procedure associated with orthodontics).

(34) teledentistry fees are inclusive with office operations and are not a separately payable service.

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