DELTA DENTAL®

Keep Smiling

DeltaCare® USA

provided by
Delta Dental of California

Dental benefits made easy!

When you enroll in a DeltaCare USA[1] plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.[2]

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums[3] for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

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

[2] Verify your selected DeltaCare USA primary care dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

deltadentalins.com/enrollees

Frequently Asked Questions

What you need to know about your DeltaCare USA plan

Getting started

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist:** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet):** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card:** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at **deltadentalins.com** and select the DeltaCare USA network. If you do not select a dentist when you enroll, we will choose one for you.

6. **Does everyone in my family have to choose the same primary care dentist?**
   No. Each family member can select his or her own primary care network dentist.[2]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or call or write to Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.

[2] In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
   No. You must visit your selected primary care network dentist to receive benefits under this plan. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists.

9. **What should I do if I need to see a specialist?**
   If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
    You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles[3] from your primary care dentist. Your out-of-area emergency benefit (typically limited to $100 per person[4]) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
    Yes. Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
    Treatment for pre-existing conditions (except work in progress[3]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

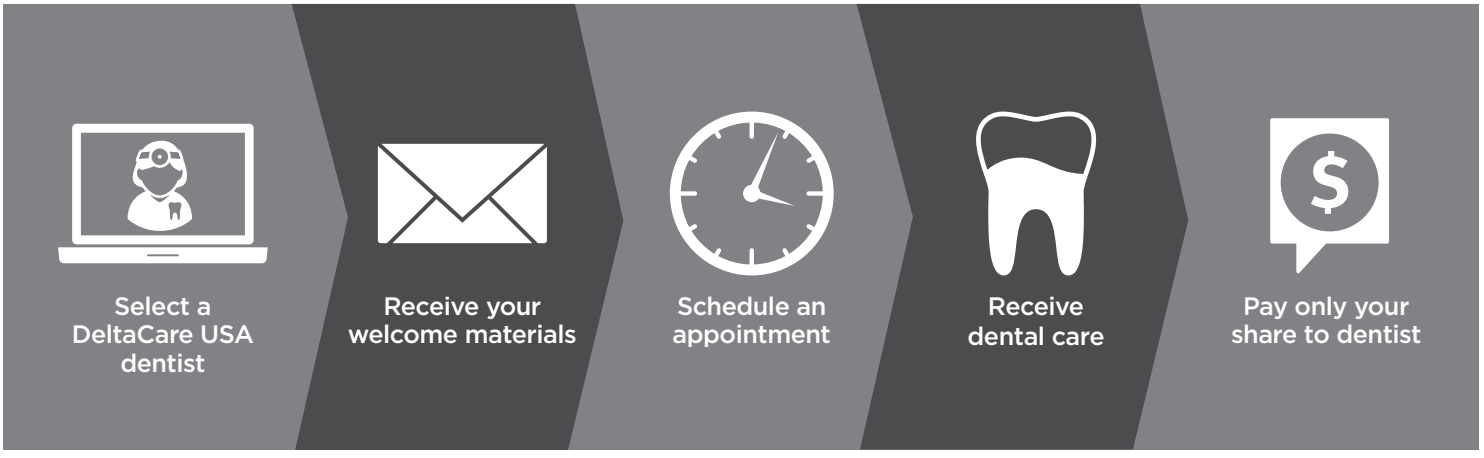
13. **Does my plan cover teeth whitening?**
    Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
    Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
    Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[4] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

We make it easy for you!



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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 Current Dental Terminology ("CDT"), CDT-2019 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
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
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	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
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost

D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$5.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$5.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	$10.00
D1516	Space maintainer - fixed - bilateral, maxillary	$10.00
D1517	Space maintainer - fixed - bilateral, mandibular	$10.00
D1520	Space maintainer - removable - unilateral	$10.00
D1526	Space maintainer - removable - bilateral, maxillary	$10.00
D1527	Space maintainer - removable - bilateral, mandibular	$10.00
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - *child to age 9*	$10.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior (*tooth colored*)	No Cost
D2331	Resin-based composite - two surfaces, anterior (*tooth colored*)	No Cost
D2332	Resin-based composite - three surfaces, anterior (*tooth colored*)	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (*tooth colored*)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
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*)	$85.00
D2394	Resin-based composite - four or more surfaces, posterior (*tooth colored*)	$95.00
D2510	Inlay - metallic - one surface [3, 6]	No Cost
D2520	Inlay - metallic - two surfaces [3, 6]	No Cost
D2530	Inlay - metallic - three or more surfaces [3, 6]	No Cost
D2542	Onlay - metallic - two surfaces [3, 6]	No Cost
D2543	Onlay - metallic - three surfaces [3, 6]	No Cost
D2544	Onlay - metallic - four or more surfaces [3, 6]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [3]	$250.00
D2620	Inlay - porcelain/ceramic - two surfaces [3]	$300.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [3]	$350.00
D2642	Onlay - porcelain/ceramic - two surfaces [3]	$320.00
D2643	Onlay - porcelain/ceramic - three surfaces [3]	$390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [3]	$420.00
D2650	Inlay - resin-based composite - one surface (*tooth colored*) [3]	$150.00
D2651	Inlay - resin-based composite - two surfaces (*tooth colored*) [3]	$200.00
D2652	Inlay - resin-based composite - three or more surfaces (*tooth colored*) [3]	$250.00
D2662	Onlay - resin-based composite - two surfaces (*tooth colored*) [3]	$200.00
D2663	Onlay - resin-based composite - three surfaces (*tooth colored*) [3]	$250.00
D2664	Onlay - resin-based composite - four or more surfaces (*tooth colored*) [3]	$300.00
D2710	Crown - resin-based composite (indirect) [3]	$35.00
D2710	Crown - resin-based composite (indirect) - (*molars*) [3]	$185.00
D2712	Crown - 3/4 resin-based composite (indirect) [3]	$35.00
D2712	Crown - 3/4 resin-based composite (indirect) - (*molars*) [3]	$185.00
D2720	Crown - resin with high noble metal [3]	$150.00

D2720	Crown - resin with high noble metal - (*molars*) [3]	$300.00
D2721	Crown - resin with predominantly base metal [3]	$50.00
D2721	Crown - resin with predominantly base metal - (*molars*) [3]	$200.00
D2722	Crown - resin with noble metal [3]	$50.00
D2722	Crown - resin with noble metal - (*molars*) [3]	$200.00
D2740	Crown - porcelain/ceramic [3]	$50.00
D2740	Crown - porcelain/ceramic - (*molars*) [3]	$200.00
D2750	Crown - porcelain fused to high noble metal [3]	$150.00
D2750	Crown - porcelain fused to high noble metal - (*molars*) [3]	$300.00
D2751	Crown - porcelain fused to predominantly base metal [3]	$50.00
D2751	Crown - porcelain fused to predominantly base metal - (*molars*) [3]	$200.00
D2752	Crown - porcelain fused to noble metal [3]	$50.00
D2752	Crown - porcelain fused to noble metal - (*molars*) [3]	$200.00
D2780	Crown - 3/4 cast high noble metal [3]	$150.00
D2781	Crown - 3/4 cast predominantly base metal [3]	$50.00
D2782	Crown - 3/4 cast noble metal [3]	$50.00
D2783	Crown - 3/4 porcelain/ceramic [3]	$50.00
D2783	Crown - 3/4 porcelain/ceramic - (*molars*) [3]	$200.00
D2790	Crown - full cast high noble metal [3]	$150.00
D2791	Crown - full cast predominantly base metal [3]	$50.00
D2792	Crown - full cast noble metal [3]	$50.00
D2794	Crown - titanium [3]	$150.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior) (tooth colored)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$5.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$5.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated [6]	No Cost
D2953	Each additional indirectly fabricated post - same tooth [6]	No Cost
D2954	Prefabricated post and core in addition to crown	No Cost
D2957	Each additional prefabricated post - same tooth	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	$10.00
D2980	Crown repair necessitated by restorative material failure	$10.00
D2981	Inlay repair necessitated by restorative material failure	$10.00
D2982	Onlay repair necessitated by restorative material failure	$10.00
D2983	Veneer repair necessitated by restorative material failure	$10.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15* .	$5.00

D3000-D3999 **IV. ENDODONTICS** ***When referable services are provided by a Participating Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's usual fee.****

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5.00

D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$5.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [1]	$45.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration) [1]	$90.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration) [1]	$125.00
D3331	Treatment of root canal obstruction; non-surgical access [1]	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth [1]	$45.00
D3346	Retreatment of previous root canal therapy - anterior [1]	$60.00
D3347	Retreatment of previous root canal therapy - premolar [1]	$105.00
D3348	Retreatment of previous root canal therapy - molar [1]	$140.00
D3410	Apicoectomy - anterior [1]	No Cost
D3421	Apicoectomy - premolar (first root) [1]	No Cost
D3425	Apicoectomy - molar (first root) [1]	No Cost
D3426	Apicoectomy (each additional root) [1]	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root [1]	No Cost
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [1]	No Cost

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$30.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$30.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4249	Clinical crown lengthening - hard tissue	$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$45.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [2, 7]	$85.00
D5120	Complete denture - mandibular [2, 7]	$85.00
D5130	Immediate denture - maxillary [2, 7]	$110.00
D5140	Immediate denture - mandibular [2, 7]	$110.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [2, 7]	$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) [2, 7]	$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [2, 7]	$110.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [2, 7]	$110.00

D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$110.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$110.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [2, 7]	$160.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [2, 7]	$160.00
D5410	Adjust complete denture - maxillary [7]	No Cost
D5411	Adjust complete denture - mandibular [7]	No Cost
D5421	Adjust partial denture - maxillary [7]	No Cost
D5422	Adjust partial denture - mandibular [7]	No Cost
D5511	Repair broken complete denture base, mandibular	$15.00
D5512	Repair broken complete denture base, maxillary	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$5.00
D5611	Repair resin partial denture base, mandibular	$15.00
D5612	Repair resin partial denture base, maxillary	$15.00
D5621	Repair cast partial framework, mandibular	$15.00
D5622	Repair cast partial framework, maxillary	$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$15.00
D5640	Replace broken teeth - per tooth	$5.00
D5650	Add tooth to existing partial denture	$5.00
D5660	Add clasp to existing partial denture - per tooth	$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$75.00
D5710	Rebase complete maxillary denture [5]	$35.00
D5711	Rebase complete mandibular denture [5]	$35.00
D5720	Rebase maxillary partial denture [5]	$35.00
D5721	Rebase mandibular partial denture [5]	$35.00
D5730	Reline complete maxillary denture (chairside) [5]	No Cost
D5731	Reline complete mandibular denture (chairside) [5]	No Cost
D5740	Reline maxillary partial denture (chairside) [5]	No Cost
D5741	Reline mandibular partial denture (chairside) [5]	No Cost
D5750	Reline complete maxillary denture (laboratory) [5]	$25.00
D5751	Reline complete mandibular denture (laboratory) [5]	$25.00
D5760	Reline maxillary partial denture (laboratory) [5]	$25.00
D5761	Reline mandibular partial denture (laboratory) [5]	$25.00
D5820	Interim partial denture (maxillary) [7]	No Cost
D5821	Interim partial denture (mandibular) [7]	No Cost
D5850	Tissue conditioning, maxillary [5, 7]	No Cost
D5851	Tissue conditioning, mandibular [5, 7]	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

D6210	Pontic - cast high noble metal [8]	$150.00
D6211	Pontic - cast predominantly base metal [8]	$50.00
D6212	Pontic - cast noble metal [8]	$50.00
D6240	Pontic - porcelain fused to high noble metal [8]	$150.00
D6240	Pontic - porcelain fused to high noble metal - (*molars*) [8]	$300.00
D6241	Pontic - porcelain fused to predominantly base metal [8]	$50.00
D6241	Pontic - porcelain fused to predominantly base metal - (*molars*) [8]	$200.00

D6242	Pontic - porcelain fused to noble metal [8]	$50.00
D6242	Pontic - porcelain fused to noble metal - (*molars*) [8]	$200.00
D6245	Pontic - porcelain/ceramic [8]	$50.00
D6245	Pontic - porcelain/ceramic - (*molars*) [8]	$200.00
D6250	Pontic - resin with high noble metal [8]	$150.00
D6250	Pontic - resin with high noble metal - (*molars*) [8]	$300.00
D6251	Pontic - resin with predominantly base metal [8]	$50.00
D6251	Pontic - resin with predominantly base metal - (*molars*) [8]	$200.00
D6252	Pontic - resin with noble metal [8]	$50.00
D6252	Pontic - resin with noble metal - (*molars*) [8]	$200.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces [8]	$300.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [8]	$350.00
D6602	Retainer inlay - cast high noble metal, two surfaces [8]	$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces [8]	$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces [8]	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [8]	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces [8]	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces [8]	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces [8]	$320.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [8]	$390.00
D6610	Retainer onlay - cast high noble metal, two surfaces [8]	$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces [8]	$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces [8]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces [8]	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces [8]	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces [8]	No Cost
D6720	Retainer crown - resin with high noble metal [8]	$150.00
D6720	Retainer crown - resin with high noble metal - (*molars*) [8]	$300.00
D6721	Retainer crown - resin with predominantly base metal [8]	$50.00
D6721	Retainer crown - resin with predominantly base metal - (*molars*) [8]	$200.00
D6722	Retainer crown - resin with noble metal [8]	$50.00
D6722	Retainer crown - resin with noble metal - (*molars*) [8]	$200.00
D6740	Retainer crown - porcelain/ceramic [8]	$50.00
D6740	Retainer crown - porcelain/ceramic - (*molars*) [8]	$200.00
D6750	Retainer crown - porcelain fused to high noble metal [8]	$150.00
D6750	Retainer crown - porcelain fused to high noble metal - (*molars*) [8]	$300.00
D6751	Retainer crown - porcelain fused to predominantly base metal [8]	$50.00
D6751	Retainer crown - porcelain fused to predominantly base metal - (*molars*) [8]	$200.00
D6752	Retainer crown - porcelain fused to noble metal [8]	$50.00
D6752	Retainer crown - porcelain fused to noble metal - (*molars*) [8]	$200.00
D6780	Retainer crown - 3/4 cast high noble metal [8]	$150.00
D6781	Retainer crown - 3/4 cast predominantly base metal [8]	$50.00
D6782	Retainer crown - 3/4 cast noble metal [8]	$50.00
D6783	Retainer crown - 3/4 porcelain/ceramic [8]	$50.00
D6783	Retainer crown - 3/4 porcelain/ceramic - (*molars*) [8]	$200.00
D6790	Retainer crown - full cast high noble metal [8]	$150.00
D6791	Retainer crown - full cast predominantly base metal [8]	$50.00
D6792	Retainer crown - full cast noble metal [8]	$50.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker [8]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$10.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	$40.00
D7240	Removal of impacted tooth - completely bony	$50.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$70.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$70.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8050	Interceptive orthodontic treatment of the primary dentition [4]	$1,400.00
D8060	Interceptive orthodontic treatment of the transitional dentition [4]	$1,400.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [4]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [4]	$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [4]	$1,800.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [9]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers) [10]	$250.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$100.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$100.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$100.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$100.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost

D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$150.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

Accident Injury Benefit - this Program provides coverage for dental accident injuries up to 100 percent of the Dentist's usual fee, less any applicable Enrollee Copayments, to a maximum of $1,600.00 per Enrollee, in any 12-month period. The Benefit is subject to the limitations and exclusions of the Program.

FOOTNOTES

1 *A Benefit for permanent teeth only.*

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

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

4 *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 $125.00 applies.*

5 *Limited to 1 per denture during any 12 consecutive months.*

6 *Base or noble metal is the benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade.*

7 *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.*

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

9 *In the event orthodontic treatment is not required or is declined by the Enrollee, a fee of $25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

10 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee not to exceed $125.00 applies.*

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.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
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.
5. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
6. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
7. 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.
8. 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.
9. A covered metallic inlay, onlay, or 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.
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. Clinical crown lengthening - hard tissue is limited to one per tooth per lifetime.
14. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
16. 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 #7.
    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.

17. 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.
18. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
19. 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.
20. 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.
21. Retained primary teeth shall be covered as primary teeth.
22. 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.
23. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
24. External bleaching is limited to fabrication of one bleaching tray per arch; bleaching gel for two weeks of patient self treatment; and no more than one treatment per arch, per 36 months.
25. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
26. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
27. Emergency Services - The Contract Dentist is responsible for providing covered emergency dental care while an Enrollee is within 35 miles of the Contract Dentist's facility. If an Enrollee requires emergency dental care and is more than 35 miles from the Contract Dentist's facility, then Delta Dental will reimburse the Enrollee for the cost of covered emergency dental care, less any applicable Enrollee copayments, to a maximum of $100.00 per Enrollee, per emergency. Emergency dental care is limited to listed procedures required to alleviate severe pain, swelling and/or bleeding or to avoid placing the Enrollee's health in serious jeopardy. Any further treatment of the cause of such emergency dental care must be preauthorized by Delta Dental or provided by the assigned Contract Dentist. All services are subject to the limitations and exclusions of the program.
28. Accident Injury Benefit - An accident injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

    Delta Dental will pay up to 100 percent of the Dentist's usual fee, for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a maximum of $1,600.00 in any 12-month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*: D7270 tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits are subject to *Schedule B, Limitations and Exclusions of Benefits*, excluding Limitations #7, 16, and 17. Benefits are limited to services provided as a result of an accident that occurred:

a. while the Enrollee was covered under the DeltaCare USA program, **or**

b. while the Enrollee was covered under another DeltaCare USA program, provided benefits for the expenses incurred would have been paid had the Enrollee continued to be eligible under that program.

29. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

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 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA 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.
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 a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call Delta Dental's 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 the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics (unless qualified for the orthodontic treatment in progress provision).

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 which 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, except as provided in Section 1373(a) of the California Health and Safety Code.

21. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

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

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Delta Dental's Contract Orthodontists. Start-up fees, retention fees, and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by the selected Contract Orthodontist.

2. Orthodontic Copayments are listed on *Schedule A, Description of Benefits and Copayments* for both interceptive and comprehensive orthodontic treatment. Additional fees will be charged for start-up and retention.

3. Benefits cover 24 months of active interceptive orthodontic treatment.

4. Benefits cover 24 months of active comprehensive orthodontic treatment, including initial banding, de-banding and any commonly used appliances such as headgear.

5. Following benefited interceptive or 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.

6. Treatment plans extending beyond 24 months of active interceptive or comprehensive orthodontic treatment, or 24 months of retention, will be subject to a monthly office visit fee to the Enrollee not to exceed $125.00 per month.

7. 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 $2,800.00 for Enrollees and covered dependents to age 19 and $3,000.00 for Enrollees and covered dependents over age 19. 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.

8. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

9. 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.

10. 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.

11. 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 Contract 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.

12. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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.

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. Restorative work caused by orthodontic treatment.

10. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.

11. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

12. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

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

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Delta Dental Insurance Company
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Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.
This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.

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