DELTA DENTAL®



Benefit highlights

DeltaCare® USA

DeltaCare USA[1] offers you straightforward and affordable care from a trusted in-network dentist that you choose. You know everything your plan covers and what each procedure costs. No surprises.

Comprehensive coverage

- Coverage for 350+ procedures
- Regular preventive care at low or no cost to help stop serious problems from developing
- Specialist services for oral surgery, endodontics, orthodontics, periodontics and pediatric dentistry

Budget-friendly

- No deductibles or maximums for covered services[2]
- Transparent out-of-pocket costs listed in your plan booklet or online account[2]
- All-inclusive copayments (no material or lab fees)
- Cleanings and exams covered at low or no cost

Large network of quality dentists

Delta Dental is a leading national carrier that offers a large network of high-quality and rigorously vetted dentists to choose from.

Convenient services

We make it easy for you — your DeltaCare USA network dentist will take care of all the paperwork, and no ID card is required to receive treatment.[3]

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.

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.

[2] Exceptions may apply in open access states (AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT AND WY).

[3] Delta Dental Insurance Company provides benefits as a Prepaid Limited Health Services Organization as described in Chapter 636 of the Florida Statutes.

deltadentalins.com/members

What you need to know in advance, or about your DeltaCare® USA plan

How DeltaCare USA works

We make it easy for you — your DeltaCare USA network dentist will take care of all the paperwork, and no plan ID card is required to receive treatment.

- **You must visit** a DeltaCare USA general dentist to use your plan.[1]
  - Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist. Your general dentist will coordinate and refer you to specialists for care, if needed.
- **You may select** an in-network general dentist, or a general dentist can be assigned at first visit if you haven't selected a dentist yet.[2]
- **You can select** or change dentists anytime online or by phone.
- **Pay predefined copayments** shown in your plan booklet or online account at the time of service.
- **No deductibles, maximums or waiting periods** for covered services. No claims to submit — no hassle!

What your plan covers

You're covered for hundreds of procedures with no annual limit on the amount your plan pays.

- Comprehensive coverage for 350+ procedures that prioritizes preventive care
- Cleanings and exams covered with low or no copayments
- Orthodontics coverage for adults and children, including clear aligners
- Extensive care including crowns, dentures, root canals, oral surgery and more

Getting started

To enroll in a DeltaCare USA plan, simply complete the enrollment process as directed by your benefits administrator. Select a new DeltaCare USA dentist or check to see if your preferred general dentist is in-network.

Once we process your enrollment, we'll mail you welcome materials that will include:

- **The name, address and phone number of your selected general dentist or instructions on how to select one.** Simply call the dental facility to make an appointment. Important note: In order to receive benefits under your plan, you must visit your general dentist facility. You can visit any DeltaCare USA general dentist at your selected dental facility as long as they are in the DeltaCare USA network.
- **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.

Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your general dentist and more.

General plan information

You and your eligible dependents have emergency dental service coverage for out-of-area emergencies when you are more than 35 miles from your selected general dentist.[3] Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to see your

[1] In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.

[2] If you have not yet been assigned to a DeltaCare USA general dentist, you can do so by visiting any DeltaCare USA general dentist that is accepting new patients. When your selected dentist files a qualifying claim, you will be added to their roster and they will become your assigned DeltaCare USA general dentist. Once assigned, you must visit this dentist for future visits to receive benefits. Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist.

[3] Exceptions may apply. Refer to your Evidence/Certificate of Coverage.

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We make it easy for you!



Receive your welcome materials



Visit your DeltaCare USA dentist



Receive dental care



Pay only your copayment

general dentist.[4] Standard plan limitations, exclusions and copayments may apply.

There are no exclusions for most pre-existing conditions, except work in progress.[5] 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.

Glossary

Here are some common terms that will help you understand your plan:

Authorization: The process by which Delta Dental determines whether a procedure or treatment is a referable benefit under your plan. Your assigned general dentist must obtain prior authorization from us to refer you to an out-of-network specialist or out-of-network orthodontist. Services performed by an out-of-network dentist, specialist or orthodontist that are not authorized by us will not be covered.

Copayment, or copay amount: The fixed dollar amount a member is responsible for when receiving treatment.

DeltaCare USA dentist: A dentist who is a member of the DeltaCare USA network. These dentists have contracted with Delta Dental and agreed to accept negotiated fees for the services provided to DeltaCare USA members. You must visit a DeltaCare USA dentist to receive plan benefits.

Diagnostic and preventive services: A category of dental services that includes benefits for oral evaluations, routine cleanings, x-rays and fluoride treatments. There are low or no copayments for these services to encourage you to seek regular care and prevent problems from developing.

Effective date: The date your dental plan becomes active. Also, the date a member becomes eligible for benefits.

Limitations and Exclusions: Limitations are usually related to a specific time or frequency — for example, a plan may cover only two cleanings in a 12-month period or one cleaning every six months. Exclusions are services not covered by a plan.

(Dental) Referral: Directing a patient to a dental specialist by a general dentist. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.[6]

Specialist services: Services performed by a dental specialist, such as oral surgery, endodontics, periodontics or pediatric dentistry. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.[6]

For more help with understanding dental terms, visit **www1.deltadentalins.com/members/glossary.html**

[4] In TX, there is no limit on the number of miles or on the dollar amount per emergency.

[5] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

[6] Dependent children covered under a DeltaCare USA plan have the option to seek dental care from a pediatric dentist through the age of 13, whether or not the child has an assigned general dentist. Referrals to visit a pediatric specialist are not required. If the pediatric dentist determines that additional specialty care is needed, they may refer pediatric patients directly to other specialists, such as an orthodontist. At age 14, covered dependent children must obtain care from their assigned DeltaCare USA general dentist.

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SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your 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 Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 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	No Cost
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 - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	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
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
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	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 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost

D0709	Intraoral - comprehensive series of radiographic images - image capture only	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
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	No Cost
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	No Cost
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	No Cost

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	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior [3, 6]	Optional
D2392	Resin-based composite - two surfaces, posterior [3, 6]	Optional
D2393	Resin-based composite - three surfaces, posterior [3, 6]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [3, 6]	Optional
D2510	Inlay - metallic - one surface [4, 7]	No Cost
D2520	Inlay - metallic - two surfaces [4, 7]	No Cost
D2530	Inlay - metallic - three or more surfaces [4, 7]	No Cost
D2542	Onlay - metallic - two surfaces [4, 7]	No Cost
D2543	Onlay - metallic - three surfaces [4, 7]	No Cost
D2544	Onlay - metallic - four or more surfaces [4, 7]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [3, 4]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces [3, 4]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces [3, 4]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [3, 4]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [3, 4]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [3, 4]	Optional

D2650	Inlay - resin-based composite - one surface [3, 4]	Optional
D2651	Inlay - resin-based composite - two surfaces [3, 4]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [3, 4]	Optional
D2662	Onlay - resin-based composite - two surfaces [3, 4]	Optional
D2663	Onlay - resin-based composite - three surfaces [3, 4]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [3, 4]	Optional
D2710	Crown - resin-based composite (indirect) [4, 8]	No Cost
D2712	Crown - 3/4 resin-based composite (indirect) [4, 8]	No Cost
D2720	Crown - resin with high noble metal [4, 7, 8]	No Cost
D2721	Crown - resin with predominantly base metal [4, 8]	No Cost
D2722	Crown - resin with noble metal [4, 8]	No Cost
D2740	Crown - porcelain/ceramic [4, 8]	No Cost
D2750	Crown - porcelain fused to high noble metal [4, 7, 8]	No Cost
D2751	Crown - porcelain fused to predominantly base metal [4, 8]	No Cost
D2752	Crown - porcelain fused to noble metal [4, 8]	No Cost
D2753	Crown - porcelain fused to titanium and titanium alloys	No Cost
D2780	Crown - 3/4 cast high noble metal [4, 7]	No Cost
D2781	Crown - 3/4 cast predominantly base metal [4]	No Cost
D2782	Crown - 3/4 cast noble metal [4]	No Cost
D2790	Crown - full cast high noble metal [4, 7]	No Cost
D2791	Crown - full cast predominantly base metal [4]	No Cost
D2792	Crown - full cast noble metal [4]	No Cost
D2794	Crown - titanium and titanium alloys [4, 7]	No Cost
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)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
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*	No Cost
D2940	Placement of interim direct restoration	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 - *includes canal preparation* [7]	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [7]	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	No Cost
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to 1 per 24 months*	No Cost

D3000-D3999 IV. ENDODONTICS

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	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [9]	No Cost
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration) [9]	No Cost
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration) [9]	No Cost
D3331	Treatment of root canal obstruction; non-surgical access [9]	No Cost
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth [9]	No Cost
D3346	Retreatment of previous root canal therapy - anterior [9]	No Cost
D3347	Retreatment of previous root canal therapy - premolar [9]	No Cost
D3348	Retreatment of previous root canal therapy - molar [9]	No Cost
D3410	Apicoectomy - anterior [9]	No Cost
D3421	Apicoectomy - premolar (first root) [9]	No Cost
D3425	Apicoectomy - molar (first root) [9]	No Cost
D3426	Apicoectomy (each additional root) [9]	No Cost
D3430	Retrograde filling - per root [9]	No Cost
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [9]	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative 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	$15.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
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
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
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 periodontal 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 with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [5, 11]	No Cost
D5120	Complete denture - mandibular [5, 11]	No Cost
D5130	Immediate denture - maxillary [5, 11]	No Cost
D5140	Immediate denture - mandibular [5, 11]	No Cost
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [5, 11]	No Cost
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) [5, 11]	No Cost

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [5, 11]	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [5, 11]	No Cost
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery [5, 11]	$50.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) [5, 11]	$50.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	No Cost
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	No Cost
D5410	Adjust complete denture - maxillary [11]	No Cost
D5411	Adjust complete denture - mandibular [11]	No Cost
D5421	Adjust partial denture - maxillary [11]	No Cost
D5422	Adjust partial denture - mandibular [11]	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost
D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture - per tooth	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken retentive/clasping materials - per tooth	No Cost
D5640	Replace missing or broken teeth - partial denture - per tooth	No Cost
D5650	Add tooth to existing partial denture - per tooth	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5710	Rebase complete maxillary denture [1]	No Cost
D5711	Rebase complete mandibular denture [1]	No Cost
D5720	Rebase maxillary partial denture [1]	No Cost
D5721	Rebase mandibular partial denture [1]	No Cost
D5725	Rebase hybrid prosthesis	No Cost
D5730	Reline complete maxillary denture (chairside) [1]	No Cost
D5731	Reline complete mandibular denture (chairside) [1]	No Cost
D5740	Reline maxillary partial denture (chairside) [1]	No Cost
D5741	Reline mandibular partial denture (chairside) [1]	No Cost
D5750	Reline complete maxillary denture (laboratory) [1]	No Cost
D5751	Reline complete mandibular denture (laboratory) [1]	No Cost
D5760	Reline maxillary partial denture (laboratory) [1]	No Cost
D5761	Reline mandibular partial denture (laboratory) [1]	No Cost
D5765	Soft liner for complete or partial removable denture - indirect	No Cost
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing* [11]	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing* [11]	No Cost
D5850	Tissue conditioning, maxillary [1, 11]	No Cost
D5851	Tissue conditioning, mandibular [1, 11]	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 [7, 12]	No Cost
D6211	Pontic - cast predominantly base metal [12]	No Cost
D6212	Pontic - cast noble metal [12]	No Cost
D6240	Pontic - porcelain fused to high noble metal [7, 8, 12]	No Cost
D6241	Pontic - porcelain fused to predominantly base metal [8, 12]	No Cost
D6242	Pontic - porcelain fused to noble metal [8, 12]	No Cost
D6243	Pontic - porcelain fused to titanium and titanium alloys	No Cost
D6245	Pontic - porcelain/ceramic [3, 12]	Optional
D6250	Pontic - resin with high noble metal [7, 8, 12]	No Cost
D6251	Pontic - resin with predominantly base metal [8, 12]	No Cost
D6252	Pontic - resin with noble metal [8, 12]	No Cost
D6600	Retainer inlay - porcelain/ceramic, two surfaces [3, 12]	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [3, 12]	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces [7, 12]	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces [7, 12]	No Cost
D6604	Retainer inlay - cast predominantly base metal, two surfaces [12]	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [12]	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces [12]	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces [12]	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces [3, 12]	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [3, 12]	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces [7, 12]	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces [7, 12]	No Cost
D6612	Retainer onlay - cast predominantly base metal, two surfaces [12]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces [12]	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces [12]	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces [12]	No Cost
D6720	Retainer crown - resin with high noble metal [7, 8, 12]	No Cost
D6721	Retainer crown - resin with predominantly base metal [8, 12]	No Cost
D6722	Retainer crown - resin with noble metal [8, 12]	No Cost
D6740	Retainer crown - porcelain/ceramic [3, 12]	Optional
D6750	Retainer crown - porcelain fused to high noble metal [7, 8, 12]	No Cost
D6751	Retainer crown - porcelain fused to predominantly base metal [8, 12]	No Cost
D6752	Retainer crown - porcelain fused to noble metal [8, 12]	No Cost
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	No Cost
D6780	Retainer crown - 3/4 cast high noble metal [7, 12]	No Cost
D6781	Retainer crown - 3/4 cast predominantly base metal [12]	No Cost
D6782	Retainer crown - 3/4 cast noble metal [12]	No Cost
D6784	Retainer crown - 3/4 titanium and titanium alloys	No Cost
D6790	Retainer crown - full cast high noble metal [7, 12]	No Cost
D6791	Retainer crown - full cast predominantly base metal [12]	No Cost
D6792	Retainer crown - full cast noble metal [12]	No Cost
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker [12]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative 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	$30.00
D7240	Removal of impacted tooth - completely bony	$40.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$40.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$40.00
D7252	Partial extraction for immediate implant placement - *Once in a lifetime*	No Cost
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	No Cost
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
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [13]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [13]	$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [13]	$1,800.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children*	$2,070.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [2]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [10]	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes START-UP FEES, (including initial examination, diagnosis, consultation and initial banding)*	$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	$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
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	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
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
D9997	Dental case management - Patients with special Health Care Needs	No Cost

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

Procedures with age restrictions will be subject to exceptions based on medical necessity.

FOOTNOTES

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

2 *In the event comprehensive orthodontic treatment is not required or is declined a fee of $25.00 will apply. You are also responsible for any incurred orthodontic diagnostic record fees.*

3 *Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions of the Plan. The applicable charge is the difference between the Contract Dentist's "submitted fee" for the Optional procedure and the "submitted fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Submitted fees" means the Contract Dentist's fees on file with Us. Questions regarding the Plan should be directed to Our Customer Service department at 800-422-4234.*

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

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

6 *An amalgam is the Benefit.*

7 *Base or noble metal is the benefit. If a crown, pontic, 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. This charge also applies to a titanium crown.*

8 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge of $150.00.*

9 *A Benefit for permanent teeth only.*

10 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

11 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six (6) months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for three (3) months following installation, if the You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

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

13 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations and Exclusions of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
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. If a biopsy is prior approved by Us to an oral surgeon, then histopathologic examination of the resulting biopsy specimen is covered and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. 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, for first molars through age nine and second molars 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.
7. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) 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 or pontic. For a cast post and core, the Benefit is for base or noble metal. If the Enrollee elects to have a high noble metal cast post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
10. 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 You elect 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.
11. If a porcelain margin is also chosen by You for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. One of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a Benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. 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.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.

17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.

18. Coverage for the placement of a fixed partial denture (bridge) requires that:

    a. No cantilevered posterior pontic (prosthetic tooth) be included; **and**

    b. One of the following:

    - The sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; **or**
    - The new bridge would replace an existing, non-functional bridge (see Limitation #9); **or**
    - Each abutment tooth to be crowned meets any limitations and exclusions.

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.

20. 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.

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. Benefits provided by a pediatric Dentist are limited to children through age 13 following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

24. In cases of accidental injury, Benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*

25. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed in *Schedule A, Description of Benefits and Copayments*. If You decline non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

26. A new removable partial, or complete denture includes after delivery adjustments and tissue conditioning, if needed, at no additional cost for the first six months after placement if You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered. Immediate dentures and immediate removable partial dentures include after delivery adjustments and tissue conditioning at no additional cost for the first three (3) months after placement.

27. 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 fees" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are Benefits.

    <u>Optional procedures include</u>:

    - The use of a tooth-colored material when restoring a posterior tooth with a filling, inlay or onlay; and
    - Units in a fixed partial denture (bridge) made of porcelain/ceramic, which is not fused to and supported by underlying cast metal.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

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

3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

6. 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.

7. 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.

8. Dispensing of drugs not normally supplied in a dental facility.

9. Any procedure that in the professional opinion of the Contract Dentist or Delta Dental's dental consultant:

   * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   * is inconsistent with generally accepted standards for dentistry.

10. 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 Us or as cited under *Emergency Services.* To obtain written Authorization, the Enrollee should call Our Customer Service department at 800-422-4234.

11. Consultations for non-covered Benefits.

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

15. 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).

16. 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 construction 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 affect any other Benefits.

17. 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.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

The DeltaCare USA Program provides coverage for orthodontic treatment plans provided through Our Contract Orthodontists. The start-up 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 Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.
4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Us will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 26. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.
5. If treatment is not required or You choose not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, You will be charged a consultation fee of $25.00 in addition to diagnostic record fees.
6. 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 and customary fee.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make Your occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.

12. 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.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
16. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
17. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

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*.

We will pay up to 100% of the Contract Dentist's "filed fees," 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*.

CODE	
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 is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

Maximum

Accident Injury Benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

Limitation

Accident Injury Benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA Program, or (b) while the Enrollee was covered under another DeltaCare USA Program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that Program.

Exclusions

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

* Prophylaxis.
* Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
* Replacement of existing restorations due to decay.
* Orthodontic services (treatment of malalignment of teeth and/or jaws).
* Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

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

More helpful tips for using your plan

Find a network dentist near you

Use our convenient **Find a dentist** tool and select **DeltaCare USA** as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Create an online account at deltadentalins.com/welcome

- Review your plan benefits
- Access your ID card if you want one (You do not need an ID card to receive services.)
- Select or change your dentist at any time

Enjoy the perks of Delta Dental coverage

Get extra member perks like oral and overall health savings, exclusive resources and more at **www1.deltadentalins.com/memberperks**.

You can also get oral health tools and tips at **deltadentalins.com/wellness**.

Contact us

Need help? Let us know.

Online: Visit **deltadentalins.com/contact**

Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 am to 9 pm ET. Or, use our automated phone system, available 24/7.

Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

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.

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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