Welcome to DeltaCare USA

DeltaCare (administered by Delta Dental Insurance Company) provides you with quality dental benefits at an affordable cost. The DeltaCare USA program is designed to encourage you to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

Plan highlights

Quality
- Extensive benefits
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

Convenience
- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 5 a.m. to 6 p.m., Pacific time

Cost savings
- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums
Eligibility
If you meet your group’s eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. Contact your benefits administrator if you have any questions.

Easy enrollment
Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities). Include the name of your group.

How your DeltaCare USA program works
Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a Delta Dental membership packet that includes an identification card and an Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the “Description of Benefits and Copayments” for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by Delta Dental to be covered by your DeltaCare USA program.

Provisions for emergency care
Under your DeltaCare USA program, you are covered for out-of-network dental emergencies. Your program pays up to $100 for out-of-network emergency dental expenses per emergency.

Accident injury benefit
The DeltaCare USA program provides coverage for accidental injury (caused by external forces) at 100% of the contract dentist’s “filed fees” for benefits (less any applicable copayments). The enrollee must be eligible under the DeltaCare USA program when the accident occurs. Accident injury benefits are subject to a $1600 maximum, per 12 months, per person.

My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?
You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists. With more than 3,800 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.
Can I change my contract dentist?
You may change contract dentists by notifying us either by phone or in writing, or by visiting our web site (www.deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

How long does it take to get an appointment with a DeltaCare USA dentist?
Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

Are pre-existing dental conditions and work in progress covered?
Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures).

How does the DeltaCare USA program encourage preventive care?
Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed “Description of Benefits and Copayments.”

Does my DeltaCare USA program cover specialists’ services?
Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics or periodontics with an approved contract specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment. If you are assigned to a dental school clinic for specialty services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

What if I have questions about my DeltaCare USA program?
Call Delta Dental Customer Service at 800-422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

“Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.”
Description of Benefits and Copayments

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

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

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>ENROLLEE PAYS</th>
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<tbody>
<tr>
<td>D0100-D0999</td>
<td>I. DIAGNOSTIC</td>
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<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
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<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
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<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
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<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
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<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report</td>
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<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
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<td>Comprehensive periodontal evaluation - new or established patient</td>
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<td>D0210</td>
<td>Intraoral radiographs - complete series (including bitewings) - <em>limited to 1 series every 36 months</em></td>
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<td>Intraoral - periapical first film</td>
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<td>Intraoral - periapical each additional film</td>
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<td>D0240</td>
<td>Intraoral - occlusal film</td>
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<td>D0270</td>
<td>Bitewing radiograph - single film</td>
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<td>D0272</td>
<td>Bitewings radiographs - two films</td>
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</tr>
<tr>
<td>D0273</td>
<td>Bitewings radiographs - three films</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings radiographs - four films - <em>limited to 1 series every 6 months</em></td>
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<tr>
<td>D0330</td>
<td>Panoramic film - <em>limited to 1 each 36 month period</em></td>
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<td>D0460</td>
<td>Pulp vitality tests</td>
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<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
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<tr>
<td>D0472</td>
<td>Accession of tissue, gross examination, preparation and transmission of written report</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
Description of Benefits and Copayments

Plan CAM57

D0473  Accession of tissue, gross and microscopic examination, preparation and transmission of written report ................................................................. No Cost

D0474  Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report ................................................................. No Cost

D0999  Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)* ................................................................. $5.00

**D1000-D1999  II. PREVENTIVE**

D1110  Prophylaxis *cleaning* - adult - 1 per 6 month period ........................................ $15.00

D1310  Nutritional counseling for control of dental disease ........................................ No Cost

D1330  Oral hygiene instructions ....................................................................................... 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 ....................................................... $27.00

D2150  Amalgam - two surfaces, primary or permanent ....................................................... $32.00

D2160  Amalgam - three surfaces, primary or permanent ....................................................... $37.00

D2161  Amalgam - four or more surfaces, primary or permanent ........................................ $50.00

D2330  Resin-based composite - one surface, anterior ......................................................... $55.00

D2331  Resin-based composite - two surfaces, anterior ......................................................... $65.00

D2332  Resin-based composite - three surfaces, anterior ....................................................... $75.00

D2335  Resin-based composite - four or more surfaces or involving incisal angle (anterior) ... $85.00

D2391  Resin-based composite - one surface, posterior ......................................................... $75.00

D2392  Resin-based composite - two surfaces, posterior ....................................................... $80.00

D2393  Resin-based composite - three surfaces, posterior .................................................... $85.00

D2394  Resin-based composite - four or more surfaces, posterior ....................................... $85.00

D2510  Inlay - metallic - one surface 1, 2 ........................................................................ $260.00

D2520  Inlay - metallic - two surfaces 1, 2 ........................................................................ $270.00

D2530  Inlay - metallic - three or more surfaces 1, 2 ............................................................ $280.00

D2542  Onlay - metallic - two surfaces 1, 2 ....................................................................... $278.00

D2543  Onlay - metallic - three surfaces 1, 2 ...................................................................... $290.00

D2544  Onlay - metallic - four or more surfaces 1, 2 ............................................................ $300.00

D2610  Inlay - porcelain/ceramic - one surface 2, 3 .............................................................. Optional

D2620  Inlay - porcelain/ceramic - two surfaces 2, 3 ............................................................. Optional

D2630  Inlay - porcelain/ceramic - three or more surfaces 2, 3 .............................................. Optional

D2642  Onlay - porcelain/ceramic - two surfaces 2, 3 ............................................................ Optional
### Description of Benefits and Copayments

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<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit</th>
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<td>D2650</td>
<td>Inlay - resin-based composite - one surface</td>
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<tr>
<td>D2651</td>
<td>Inlay - resin-based composite - two surfaces</td>
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<tr>
<td>D2652</td>
<td>Inlay - resin-based composite - three or more surfaces</td>
<td>Optional</td>
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<td>D2662</td>
<td>Onlay - resin-based composite - two surfaces</td>
<td>Optional</td>
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<td>D2663</td>
<td>Onlay - resin-based composite - three surfaces</td>
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<td>D2664</td>
<td>Onlay - resin-based composite - four or more surfaces</td>
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<td>D2710</td>
<td>Crown - resin-based composite (indirect)</td>
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<td>D2712</td>
<td>Crown - ¾ resin-based composite (indirect)</td>
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<td>D2720</td>
<td>Crown - resin with high noble metal</td>
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<td>D2721</td>
<td>Crown - resin with predominantly base metal</td>
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<td>D2722</td>
<td>Crown - resin with noble metal</td>
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<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
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<td>D2782</td>
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<td>D2791</td>
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<tr>
<td>D2792</td>
<td>Crown - full cast noble metal</td>
<td>$335.00</td>
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<tr>
<td>D2794</td>
<td>Crown - titanium</td>
<td>$365.00</td>
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<tr>
<td>D2910</td>
<td>Recement inlay, onlay or partial coverage restoration</td>
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<tr>
<td>D2915</td>
<td>Recement cast or prefabricated post and core</td>
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<tr>
<td>D2920</td>
<td>Recement crown</td>
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<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
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<tr>
<td>D2940</td>
<td>Sedative filling</td>
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<td>D2950</td>
<td>Core buildup, including any pins</td>
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<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
<td>$25.00</td>
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<tr>
<td>D2952</td>
<td>Post and core in addition to crown, indirectly fabricated - includes canal preparation</td>
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<tr>
<td>D2953</td>
<td>Each additional indirectly fabricated post - same tooth - includes canal preparation</td>
<td>$95.00</td>
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<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown - base metal post; includes canal preparation</td>
<td>$70.00</td>
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</table>
Plan CAM57

Description of Benefits and Copayments

D2957  Each additional prefabricated post - same tooth - *base metal post*;
       includes canal preparation ............................................................... $70.00
D2970  Temporary crown (fractured tooth) - *palliative treatment only* ........................................ $35.00
D2980  Crown repair, by report ......................................................................................... $45.00

D3000-D3999  IV. ENDODONTICS

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 .................................................... $35.00
D3310  *Root canal* - anterior (excluding final restoration) ..................................................... $180.00
D3320  *Root canal* - bicuspid (excluding final restoration) ..................................................... $230.00
D3330  *Root canal* - molar (excluding final restoration) ....................................................... $375.00
D3346  Retreatment of previous root canal therapy - anterior ................................................ $280.00
D3347  Retreatment of previous root canal therapy - bicuspid .............................................. $330.00
D3348  Retreatment of previous root canal therapy - molar ................................................... $475.00
D3410  Apicoectomy/periradicular surgery - anterior ............................................................ $270.00
D3421  Apicoectomy/periradicular surgery - bicuspid (first root) ............................................. $335.00
D3425  Apicoectomy/periradicular surgery - molar (first root) ................................................ $380.00
D3426  Apicoectomy/periradicular surgery (each additional root) ........................................ $105.00
D3430  Retrograde filling - per root ..................................................................................... $25.00
D3450  Root amputation, per root - *not covered in conjunction with a hemisection* ............. $75.00

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 bounded
tooth spaces per quadrant ......................................................................................... $300.00
D4211  Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded
tooth spaces per quadrant ......................................................................................... $50.00
D4240  Gingival flap procedure, including root planing - four or more contiguous
tooth or bounded teeth spaces per quadrant ........................................................... $300.00
D4241  Gingival flap procedure, including root planing - one to three contiguous
tooth or bounded teeth spaces per quadrant ........................................................... $300.00
D4260  Osseous surgery (including flap entry and closure) - four or more contiguous
tooth or bounded teeth spaces per quadrant ........................................................... $450.00
D4261  Osseous surgery (including flap entry and closure) - one to three contiguous
tooth or bounded teeth spaces per quadrant ........................................................... $450.00
D4341  Periodontal scaling and root planing - four or more teeth per quadrant -
       *limited to 4 quadrants during any 12 consecutive months* ....................................... $55.00
D4342  Periodontal scaling and root planing - one to three teeth per quadrant -
       *limited to 4 quadrants during any 12 consecutive months* ....................................... $55.00
Plan CAM57

Description of Benefits and Copayments

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis -
limited to 1 treatment in any 12 consecutive months ........................................... $55.00
D4910 Periodontal maintenance - limited to 1 treatment each 6 month period .............. $45.00

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110 Complete denture - maxillary 6,7 ........................................................................ $395.00
D5120 Complete denture - mandibular 6,7 ................................................................... $395.00
D5130 Immediate denture - maxillary 6,7 ................................................................. $495.00
D5140 Immediate denture - mandibular 6,7 ............................................................... $495.00
D5211 Maxillary partial denture - resin base (including any conventional clasps,
rests and teeth) 6,7 ................................................................................................ $300.00
D5212 Mandibular partial denture - resin base (including any conventional clasps,
rests and teeth) 6,7 ................................................................................................ $300.00
D5213 Maxillary partial denture - cast metal framework with resin denture bases
(including any conventional clasps, rests and teeth) 6,7 ........................................ $395.00
D5214 Mandibular partial denture - cast metal framework with resin denture bases
(including any conventional clasps, rests and teeth) 6,7 ........................................ $395.00
D5410 Adjust complete denture - maxillary 7 .......................................................... $20.00
D5411 Adjust complete denture - mandibular 7 ......................................................... $20.00
D5421 Adjust partial denture - maxillary 7 ............................................................... $20.00
D5422 Adjust partial denture - mandibular 7 ............................................................ $20.00
D5510 Repair broken complete denture base ............................................................. $50.00
D5520 Replace missing or broken teeth - complete denture (each tooth)............... $25.00
D5610 Repair resin denture base ................................................................................. $50.00
D5620 Repair cast framework ..................................................................................... $90.00
D5630 Repair or replace broken clasp ......................................................................... $45.00
D5640 Replace broken teeth - per tooth ..................................................................... $25.00
D5650 Add tooth to existing partial denture ............................................................... $45.00
D5660 Add clasp to existing partial denture ............................................................... $45.00
D5710 Rebase complete maxillary denture 8 ............................................................. $130.00
D5711 Rebase complete mandibular denture 8 .......................................................... $130.00
D5720 Rebase maxillary partial denture 8 ................................................................. $130.00
D5721 Rebase mandibular partial denture 8 ............................................................... $130.00
D5730 Reline complete maxillary denture (chairside) 8 ............................................. $50.00
D5731 Reline complete mandibular denture (chairside) 8 ......................................... $50.00
D5740 Reline maxillary partial denture (chairside) 8 ................................................ $50.00
D5741 Reline mandibular partial denture (chairside) 8 .............................................. $50.00
D5750 Reline complete maxillary denture (laboratory) 8 .......................................... $150.00
Plan CAM57

Description of Benefits and Copayments

D5751  Reline complete mandibular denture (laboratory) .......................... $150.00
D5760  Reline maxillary partial denture (laboratory) .......................... $150.00
D5761  Reline mandibular partial denture (laboratory) .......................... $150.00
D5820  Interim partial denture (maxillary) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing ............................................. $55.00
D5821  Interim partial denture (mandibular) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing ............................................. $55.00
D5850  Tissue conditioning, maxillary .................................................. $30.00
D5851  Tissue conditioning, mandibular .................................................. $30.00
D5860  Overdenture - complete, by report Optional
D5861  Overdenture - partial, by report Optional

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 .......................................................... $365.00
D6211  Pontic - cast predominantly base metal ............................................. $300.00
D6212  Pontic - cast noble metal ................................................................. $300.00
D6240  Pontic - porcelain fused to high noble metal ..................................... $395.00
D6241  Pontic - porcelain fused to predominantly base metal ..................... $315.00
D6242  Pontic - porcelain fused to noble metal ............................................ $350.00
D6245  Pontic - porcelain/ceramic ............................................................... $350.00
D6250  Pontic - resin with high noble metal .................................................. $395.00
D6251  Pontic - resin with predominantly base metal .................................... $315.00
D6252  Pontic - resin with noble metal ......................................................... $350.00
D6600  Inlay - porcelain/ceramic, two surfaces Optional
D6601  Inlay - porcelain/ceramic, three or more surfaces Optional
D6602  Inlay - cast high noble metal, two surfaces ....................................... $270.00
D6603  Inlay - cast high noble metal, three or more surfaces ....................... $280.00
D6604  Inlay - cast predominantly base metal, two surfaces ...................... $270.00
D6605  Inlay - cast predominantly base metal, three or more surfaces .......... $280.00
D6606  Inlay - cast noble metal, two surfaces .............................................. $270.00
D6607  Inlay - cast noble metal, three or more surfaces ................................ $280.00
D6608  Onlay - porcelain/ceramic, two surfaces Optional
D6609  Onlay - porcelain/ceramic, three or more surfaces Optional
D6610  Onlay - cast high noble metal, two surfaces ....................................... $290.00
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<th>Benefit</th>
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<td>D6611</td>
<td>Onlay - cast high noble metal, three or more surfaces</td>
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</tr>
<tr>
<td>D6612</td>
<td>Onlay - cast predominantly base metal, two surfaces</td>
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<tr>
<td>D6613</td>
<td>Onlay - cast predominantly base metal, three or more surfaces</td>
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<td>Onlay - cast noble metal, two surfaces</td>
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<td>D6615</td>
<td>Onlay - cast noble metal, three or more surfaces</td>
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<tr>
<td>D6720</td>
<td>Crown - resin with high noble metal</td>
<td>$395.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Crown - resin with predominantly base metal</td>
<td>$315.00</td>
</tr>
<tr>
<td>D6722</td>
<td>Crown - resin with noble metal</td>
<td>$350.00</td>
</tr>
<tr>
<td>D6740</td>
<td>Crown - porcelain/ceramic</td>
<td>Optional</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>$395.00</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>$315.00</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>$350.00</td>
</tr>
<tr>
<td>D6780</td>
<td>Crown - ¾ cast high noble metal</td>
<td>$335.00</td>
</tr>
<tr>
<td>D6781</td>
<td>Crown - ¾ cast predominantly base metal</td>
<td>$300.00</td>
</tr>
<tr>
<td>D6782</td>
<td>Crown - ¾ cast noble metal</td>
<td>$335.00</td>
</tr>
<tr>
<td>D6790</td>
<td>Crown - full cast high noble metal</td>
<td>$365.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Crown - full cast predominantly base metal</td>
<td>$300.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Crown - full cast noble metal</td>
<td>$335.00</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement fixed partial denture</td>
<td>$30.00</td>
</tr>
<tr>
<td>D6940</td>
<td>Stress breaker</td>
<td>$50.00</td>
</tr>
<tr>
<td>D6970</td>
<td>Post and core in addition to fixed partial denture retainer, indirectly fabricated - includes canal preparation</td>
<td>$95.00</td>
</tr>
<tr>
<td>D6972</td>
<td>Prefabricated post and core in addition to fixed partial denture retainer - base metal post; includes canal preparation</td>
<td>$85.00</td>
</tr>
<tr>
<td>D6973</td>
<td>Core buildup for retainer, including any pins</td>
<td>$50.00</td>
</tr>
<tr>
<td>D6976</td>
<td>Each additional indirectly fabricated post - same tooth - includes canal preparation</td>
<td>$95.00</td>
</tr>
<tr>
<td>D6977</td>
<td>Each additional prefabricated post - same tooth - base metal post; includes canal preparation</td>
<td>$85.00</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

**D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
<td>$35.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>$35.00</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td>$65.00</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>$75.00</td>
</tr>
</tbody>
</table>
D7230  Removal of impacted tooth - partially bony ................................................................. $100.00
D7240  Removal of impacted tooth - completely bony ............................................................ $140.00
D7241  Removal of impacted tooth - completely bony, with unusual surgical complications ... $160.00
D7250  Surgical removal of residual tooth roots (cutting procedure) ...................................... $65.00
D7286  Biopsy of oral tissue - soft - does not include pathology laboratory procedures .......... $60.00
D7310  Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ........................................................................................................ $50.00
D7311  Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ........................................................................................................ $50.00
D7320  Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ........................................................................................................ $105.00
D7321  Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ........................................................................................................ $105.00
D7471  Removal of lateral exostosis (maxilla or mandible) ........................................................ $200.00
D7510  Incision and drainage of abscess - intraoral soft tissue ................................................. $35.00
D7960  Frenulectomy (frenectomy or frenotomy) - separate procedure ..................................... $75.00

D8000-D8999 XI. ORTHODONTICS - Not Covered

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110  Palliative (emergency) treatment of dental pain - minor procedure .............................. $35.00
D9211  Regional block anesthesia ............................................................................................ No Cost
D9212  Trigeminal division block anesthesia ............................................................................. No Cost
D9215  Local anesthesia ........................................................................................................... No Cost
D9310  Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician ................................................................. $35.00
D9430  Office visit for observation (during regularly scheduled hours) - no other services performed ........................................................................................................ $5.00
D9440  Office visit - after regularly scheduled hours................................................................. $50.00
D9999  Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00 ................................................................................. $10.00

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

“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.
FOOTNOTES

1 Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of $100.00 per tooth. If an 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.

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

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 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 the DeltaCare USA program should be directed to Delta Dental’s Customer Service department at 800-422-4234.

4 Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $75.00.

5 A benefit for permanent teeth only.

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

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 Limited to 1 per denture during any 12 consecutive months.

9 Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.
SCHEDULE B
Limitations of Benefits

1. Full mouth x-rays are limited to one set every 36 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 preauthorized by Delta Dental for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.

5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.

6. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

7. 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 #11).

8. A covered metallic inlay or onlay 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. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.

9. For molars, a covered crown or unit of a fixed partial denture (bridge) is a full cast metal restoration without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $75.00 per molar.

10. 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.

11. 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. Either 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.

12. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.

13. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.

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

15. The benefit for the replacement of a missing posterior tooth (or teeth) is a removable partial denture. Coverage for the placement
of a fixed partial denture (bridge) is optional except in the following cases:

- The sole tooth to be replaced in the arch is a permanent anterior tooth, provided that it is not in conjunction with a partial denture on the same arch. A cantilever bridge is a benefit at the professional discretion of the Contract Dentist for the replacement of one missing permanent anterior tooth only; or

- The new bridge would replace an existing, non-functional bridge utilizing the same abutment teeth, with no additional abutments or pontics with the exception of posterior cantilever bridges (see Limitation #11).

- The abutment teeth are not being crowned solely for the purpose of supporting a pontic (each abutment tooth to be crowned must meet Limitation #7).

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

17. 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.

18. 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.

19. 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.

20. Soft tissue management programs include, but are not limited to, periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for covered services.

21. 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.

22. 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 fees” 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. Optional procedures include:

- 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.

“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. 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.

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.).

8. Dispensing of drugs not normally utilized in the delivery of dental services.

9. 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.

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 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.


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

13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth or the anticipation of future fractures.

14. 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).

15. 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.

16. 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.
Limitations and Exclusions of Benefits

17. 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.

18. Treatment or extraction of primary teeth.

19. A Maryland bridge is considered a specialized technique and is not a Benefit. Recementation, repair or replacement of an existing Maryland bridge is not a Benefit.

Accident Injury Benefit

An accidental 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 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:

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 #12, #17, and #19 and exclusions #1-9, #11-14 and #17-19, the following exclusions apply:

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

“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.
NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.
The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling the Customer Service department at 800-422-4234.**

*In California, DeltaCare USA is underwritten and administered by Delta Dental of California.*

**Customer Service**
800-422-4234  
Monday through Friday  
5 a.m. to 6 p.m., Pacific time

Provided and Administered by:

**Delta Dental of California**
12898 Towne Center Drive  
Cerritos, CA 90703-8579

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