

Smiles

something to smile about

ALAMEDA CONTRA COSTA MEDICAL ASSOCIATION (ACCMA)

Comparison of Dental Benefit Options

Delta Dental of California is privileged to make available these dental benefit programs for ACCMA members, their families and staff. Eligible participants can choose between two dental programs – a dental HMO plan or a preferred provider organization (PPO) plan. Outlined below is a summary of the program options and answers to commonly asked questions:

ACCMA	
Comparison of Dental Benefit Choices	
DeltaCare USA — dental HMO	Delta Dental PPO — dental PPO
<p>Functions like a medical HMO plan – enrollees choose a primary care dentist at time of enrollment or one will be assigned.</p> <p>Different family members may select different primary care dentists.</p> <p>The primary care dentist is the point of service for all dental services and will make specialist referrals when needed. The DeltaCare USA network includes more than 2,400 general dentists, 900 specialists and 300 orthodontists.</p> <p>Enrollees may change their primary care dentist by contacting DeltaCare USA’s toll-free number 800-422-4234.</p>	<p>Visit any dentist at any time, anywhere, regardless of specialty.</p> <p>Receive “in network” enhanced benefit coverage when using a PPO contracted dentist (nearly 40% of all dental locations statewide are PPO).</p> <p>When out of network, enrollees are further protected through Delta’s extended network of Delta Dental Premier dentists (nearly 92% of all dental locations statewide are Delta).</p>
Known copayments — listed by procedure	Copayments are based on a percentage of allowed charges.
No deductible	\$50 deductible per patient per calendar year
No annual maximum	There’s a \$50 deductible each year for non-Preventive services if you use a dentist that is not in Delta’s PPO network.
No yearly maximum	\$1,000 annual maximum per patient per calendar year.
No waiting periods	<p>In the first 12 months, services are limited to Diagnostic, Preventive and Simple Restorative services (e.g. cleanings, x-rays and fillings).</p> <p>In the second 12 months, services are expanded to include all other services with the exceptions of crowns, casts and prosthodontics (bridges and dentures).</p> <p>Following this initial 24-month enrollment period, services are expanded to include all routine services.</p>
Includes orthodontic coverage	Orthodontia is covered following 24 months of enrollment.

Note: This is only a brief summary of each plan. An Evidence of Coverage brochure will be provided upon enrollment stating the terms of your plan.

Important Questions and Answers about the Delta Dental PPO and DeltaCare USA (HMO) Programs

Q: Who is eligible?

A: ACCMA members, their families and office staffs are eligible for coverage.

Q: What is the enrollment period?

A: Benefit selection is for one year.

Q: Is switching allowed between the programs?

A: Enrollees may switch between the programs during an annual open enrollment period.

Q: Are there any deferrals or exceptions for the PPO waiting period?

A: No, all new enrollees in the PPO program must complete the waiting periods for expanded services. This includes PPO enrollees who have switched from the dental HMO program – they, too, must start from the base benefits.

Q: How does an enrollee find a dentist?

A: Dentist network information for both the PPO and HMO programs is available online at www.deltadentalca.org. Printed directories for the PPO program can be requested by calling 1-800-4-AREA-DR. Printed directories for the dental HMO program DeltaCare USA can be requested by calling 1-800-422-4234.

Q: What is the cost of the program?

A: You can choose the PPO program or the DeltaCare USA program. The premium table below can provide some guidelines. For more information regarding payment, please contact ACCMA Insurance Administration c/o J.C. Lewis Insurance Services, 1-800-966-1511.

Q: How do I sign up?

A: An enrollment form is included in this booklet. Complete the enrollment form and submit via mail to the address shown below. Please include your initial monthly or semi-annual premium payment:

**ACCMA Insurance Administration
J.C. Lewis Insurance Services
P.O. Box 750489
Petaluma, CA 94975-0489
CA License #0580789
800-966-1511
E-mail accma@jclis.com
FAX 707-778-8352**

ACCMA Premium Enrollment dates of 01/01/08 through 12/31/09			
Program	Self	Self plus one dependent	Self plus two or more dependents
Semi-annual payment*			
DeltaCare USA (DHMO)	\$126.00	\$207.84	\$307.68
Delta Dental PPO	\$221.16	\$411.18	\$756.24
Monthly payment			
DeltaCare USA (DHMO)	\$21.00	\$34.64	\$51.28
Delta Dental PPO	\$36.86	\$68.53	\$126.04

*Available only to people who enroll for the January 1, 2008, enrollment date; all others must select the monthly premium payment option.

Delta Dental PPO Program

ABOUT DELTA DENTAL PPO

Under the PPO plan, you can visit any licensed dentist of your choice, and your family members may select different dentists. You can change dentists at any time, go to a dental specialist of your choice and receive dental care anywhere in the world.

To make the *most* of your benefits and pay the *lowest* out-of-pocket costs under the Delta Dental PPO plan, we recommend you visit a Delta Dental PPO network dentist (92,000 dentist locations nationwide; more than 13,000 in California).

If you choose a dentist who is not in the PPO network, but you choose to have services from a Delta Dental Premier dentist, you will benefit from guaranteed copayments limited to the approved Delta Dental Premier fees. You won't receive this cost protection and other conveniences when you visit a non-Delta dentist.

IN-NETWORK	OUT-OF-NETWORK	
DELTA DENTAL PPO DENTISTS	DELTA DENTAL PREMIER DENTISTS	NON-DELTA DENTISTS
Your out-of-pocket expense will likely be less because PPO dentists have agreed to charge PPO patients reduced fees.	You will be charged no more than the fees approved by Delta Dental (Premier dentist fees are generally higher than PPO dentist fees).	You will be responsible for the difference if your dentist charges more than Delta Dental's approved fees.
You may be charged only the patient share* at the time of treatment, not Delta Dental's portion.	You may be charged only the patient share* at the time of treatment, not Delta Dental's portion (patient share is likely to be higher compared to a PPO dentist).	You may have to pay the entire amount in advance and wait for reimbursement.
Claim forms will be completed and submitted for you at no charge.	You may be charged only the patient share* at the time of treatment, not Delta's portion.	You may have to complete and submit your own claim forms or pay a service fee.

**"Patient share" is the copayment, applicable deductible and any amount over the annual maximum. Some services may not be covered; please refer to your Evidence of Coverage or Summary Plan Description. Examples of services not covered are cosmetic dentistry, experimental procedures and services to correct congenital malformations.*

THIS BOOKLET IS ONLY A BRIEF SUMMARY OF THE DENTAL PLAN. THE DENTAL CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

PRINCIPAL BENEFITS AND COVERED SERVICES*

WHEN TREATMENT IS PROVIDED BY . . .	A PPO IN-NETWORK DENTIST	AN OUT-OF-NETWORK DENTIST
WHO'S COVERED	Primary enrollee, spouse or domestic partner well as dependent children to age 19 and full-time students to age 25	Primary enrollee, spouse or domestic partner well as dependent children to age 19 and full-time students to age 25
DEDUCTIBLES AND BENEFITS MAXIMUM	\$50 per person per calendar year. The maximum benefit paid per calendar year is \$1,000 per person.	\$50 per person per calendar year. The maximum benefit paid per calendar year is \$1,000 per person.
BENEFITS — First year		
Diagnostic and Preventive	100% of Delta Dental PPO dentist's allowed fee (no deductible applies to these services)	50% of Delta Dental allowed fee (no deductible applies to these services)
Basic — sealants, simple restorations and extractiions	80% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental dentist's allowed fee
ADDITIONAL BENEFITS — Second year¹		
Basic — miscellaneous restorations	80% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Basic — oral surgery	80% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Basic — endodontics	80% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
ADDITIONAL BENEFITS — Third year²		
Basic — periodontics	50% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Crowns, jackets and cast restorations	50% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Prosthodontics	50% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Implants	50% of Delta Dental PPO dentist's allowed fee	50% of Delta Dental allowed fee
Orthodontics (adults & dependent children)	50% of Delta Dental PPO dentist's allowed fee (subject to a \$1,000 lifetime per patient)	50% of Delta Dental allowed fee (subject to a \$1,000 lifetime per patient)

*Please refer to your Evidence of Coverage for limitations on these benefits.

Some examples of limitations on services are the number of cleanings and oral exams covered in a calendar year, and time limitations on filling and crown replacements. benefits when visiting one of these specialists.

¹Covered only following 12 months of continuous enrollment.

²Covered only following 24 months of continuous enrollment.

PPO IS EASY TO USE — GROUP #2704

PPO is Delta's preferred provider plan. The plan provides the maximum benefit when you visit a PPO dentist. PPO dentists are Delta dentists who have agreed to charge PPO patients reduced fees.

To use your PPO program, just call the dental office of your choice and make an appointment. During your first appointment, give your dentist your group number, which is at the top of this page, and the primary enrollee's social security number. When you call a PPO dentist for an appointment, please confirm that the dentist participates in the PPO network.

For a list of PPO or Delta dentists in your area, search the dentist directory on our web site at www.deltadentalca.org or call our toll-free automated telephone service at 800-4-AREA-DR (800-427-3237). You can also check with your benefits administrator, who has a complete list of PPO and Delta dentists.

Visit our web site to view your eligibility and benefits or print your own ID card. (Note: You do not need an ID card to verify coverage, make an appointment or receive treatment.) You also can have eligibility information faxed to you by calling toll-free 800-765-6003.

Delta Dental of California offers you what no other dental plan can — The Delta Difference®. Here's what makes us unique:

- ▶ *Determination of fees.* PPO and Premier dentists agree to our determination of fees.
- ▶ *Copayments are guaranteed.* PPO and Premier dentists may charge you only what Delta Dental determines to be your share of the treatment cost. Your copayments will most likely be lowest when you visit a PPO dentist.
- ▶ *We require professional treatment standards.* PPO and Premier dentists must meet professional standards for hygiene, radiation safety and other areas related to quality care.

These are just a few of the reasons that *one in three Californians* count on Delta Dental for dental care benefits.

SERVICES THAT ARE *NOT* COVERED UNDER PPO

Although your plan covers many of the most commonly needed services, some services are not covered. If you are unsure whether a particular procedure is covered, or how much of it is paid for by your plan, check with Delta before proceeding.

The following are not covered by the plan:

- ▶ Services for injuries or conditions covered under Workers' Compensation or Employer's Liability Laws
- ▶ Cosmetic surgery or dentistry or services to correct congenital malformation
- ▶ Experimental procedures
- ▶ Therapeutic drugs, premedication or pain relievers
- ▶ Hospital costs or extra charges for hospital treatment
- ▶ Anesthesia (except for general anesthesia for oral surgery)
- ▶ Extra-oral grafts
- ▶ Treatment related to the temporomandibular joint (TMJ)

The preceding information is not intended for use as a summary plan description, nor is it designed to serve as an Evidence of Coverage for the plan.

The Delta Dental PPO program is administered by Delta Dental of California. If you have specific questions regarding benefit structure, limitations or exclusions, consult the Evidence of Coverage or contact Delta's Customer Service department.



P. O. Box 997330
Sacramento, CA 95899-7330

For customer service:
800-765-6003

For automated or faxed eligibility/benefits information:
800-765-6003

For online eligibility/benefits information:
www.deltadentalca.org

For a list of Delta dentists:
800-4-AREA-DR (800-427-3237) or www.deltadentalca.org

DeltaCare USA

HIGHLIGHTS OF YOUR DELTACARE USA PROGRAM

Eligibility for you and your family

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. 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) for both yourself and your eligible dependents. 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 DeltaCare USA membership packet including an identification card and an Evidence of Coverage 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 DeltaCare USA to be covered by your DeltaCare USA program.

Provisions for emergency care

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist). Your program pays up to \$100 for out-of-area emergency dental expenses incurred in each 12-month period for each enrollee.

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 \$1,600 maximum, per 12 months, per person.

My dentist is a Delta 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 dentists are not necessarily DeltaCare USA dentists. With more than 2,400 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.

Do my family members receive treatment from the same DeltaCare USA contract dentist?

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

Can I change my contract dentist?

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (www.deltadentalca.org). If you contact us by the 21st of the month, the change will become effective the first of the following month.

Can I have teeth whitened under the DeltaCare USA Program?

External bleaching is a benefit under your Program, subject to certain limitations. Talk to your contract dentist about your options.

Does my DeltaCare USA Program cover tooth-colored fillings and crowns on molars?

The upgrade to porcelain and other tooth-colored materials on molars is included as a benefit under your Program. The copayment shows you what your out of pocket cost will be.

How long does it take to get an appointment with a DeltaCare USA dentist?

Three 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, periodontics or pediatric dentistry with an approved contract specialist. There is no additional charge to you for receiving care from a 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 DeltaCare USA 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.

SCHEDULE A – DESCRIPTION OF BENEFITS AND COPAYMENTS

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

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

Code	Description	Enrollee Pays
D0100-D0999 I. DIAGNOSTIC		
D0120	Periodic oral evaluation — established patient	No Cost
D0140	Limited oral evaluation — problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation — new or established patient	No Cost
D0160	Detailed and extensive oral evaluation — problem focused, by report	No Cost
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation — new or established patient	No Cost
D0210	Intraoral <i>radiographs</i> — complete series (including bitewings) — <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral — periapical first film	No Cost
D0230	Intraoral — periapical each additional film	No Cost
D0240	Intraoral — occlusal film	No Cost
D0250	Extraoral — first film	No Cost
D0260	Extraoral — each additional film	No Cost
D0270	Bitewing <i>radiograph</i> — single film	No Cost
D0272	Bitewings <i>radiographs</i> — two films	No Cost
D0273	Bitewings <i>radiographs</i> — three films	No Cost
D0274	Bitewings <i>radiographs</i> — four films — <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings — 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report — <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999 II. PREVENTIVE		
D1110	Prophylaxis cleaning — adult — <i>1 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning — adult (within the 6 month period)</i>	\$45.00
D1120	Prophylaxis cleaning — child — <i>1 per 6 month period</i>	No Cost
D1120	<i>Additional prophylaxis cleaning — child (within the 6 month period)</i>	\$35.00
D1203	Topical application of fluoride (prophylaxis not included) — child — <i>to age 19; 1 per 6 month period</i>	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients — <i>child to age 19; 1 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant — per tooth — <i>limited to permanent molars through age 15</i>	\$10.00
D1510	Space maintainer — fixed — unilateral	\$25.00
D1515	Space maintainer — fixed — bilateral	\$25.00
D1520	Space maintainer — removable — unilateral	\$25.00
D1525	Space maintainer — removable — bilateral	\$25.00

Code	Description	Enrollee Pays
D1550	Re-cementation of space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D2000-D2999 III. RESTORATIVE		
<i>Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.</i>		
<i>— When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.</i>		
<i>— Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.</i>		
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 or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	\$35.00
D2391	Resin-based composite — one surface, posterior	\$55.00
D2392	Resin-based composite — two surfaces, posterior	\$65.00
D2393	Resin-based composite — three surfaces, posterior	\$75.00
D2394	Resin-based composite — four or more surfaces, posterior	\$85.00
D2510	Inlay — metallic — one surface	No Cost
D2520	Inlay — metallic — two surfaces	No Cost
D2530	Inlay — metallic — three or more surfaces	No Cost
D2542	Onlay — metallic — two surfaces	No Cost
D2543	Onlay — metallic — three surfaces	No Cost
D2544	Onlay — metallic — four or more surfaces	No Cost
D2610	Inlay — porcelain/ceramic — one surface	\$165.00
D2620	Inlay — porcelain/ceramic — two surfaces	\$190.00
D2630	Inlay — porcelain/ceramic — three or more surfaces	\$200.00
D2642	Onlay — porcelain/ceramic — two surfaces	\$185.00
D2643	Onlay — porcelain/ceramic — three surfaces	\$205.00
D2644	Onlay — porcelain/ceramic — four or more surfaces	\$220.00
D2650	Inlay — resin-based composite — one surface	\$105.00
D2651	Inlay — resin-based composite — two surfaces	\$120.00
D2652	Inlay — resin-based composite — three or more surfaces	\$145.00
D2662	Onlay — resin-based composite — two surfaces	\$140.00
D2663	Onlay — resin-based composite — three surfaces	\$155.00
D2664	Onlay — resin-based composite — four or more surfaces	\$185.00
D2710	Crown — resin-based composite (indirect)	\$50.00
D2712	Crown — 3/4 resin-based composite (indirect)	\$50.00
D2720	Crown — resin with high noble metal	\$195.00
D2721	Crown — resin with predominantly base metal	\$95.00
D2722	Crown — resin with noble metal	\$135.00
D2740	Crown — porcelain/ceramic substrate	\$240.00
D2750	Crown — porcelain fused to high noble metal	\$240.00
D2751	Crown — porcelain fused to predominantly base metal	\$140.00
D2752	Crown — porcelain fused to noble metal	\$180.00
D2780	Crown — 3/4 cast high noble metal	\$210.00
D2781	Crown — 3/4 cast predominantly base metal	\$110.00
D2782	Crown — 3/4 cast noble metal	\$150.00
D2783	Crown — 3/4 porcelain/ceramic	\$240.00
D2790	Crown — full cast high noble metal	\$210.00
D2791	Crown — full cast predominantly base metal	\$110.00
D2792	Crown — full cast noble metal	\$150.00
D2794	Crown — titanium	\$240.00

Code	Description	Enrollee Pays
D2910	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown — primary tooth	\$15.00
D2931	Prefabricated stainless steel crown — permanent tooth	\$15.00
D2932	Prefabricated resin crown — <i>anterior primary tooth</i>	\$25.00
D2933	Prefabricated stainless steel crown with resin window — <i>anterior primary tooth</i>	\$20.00
D2940	Sedative filling	\$5.00
D2950	Core buildup, including any pins	\$15.00
D2951	Pin retention — per tooth, in addition to restoration	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated — <i>includes canal preparation</i>	\$35.00
D2953	Each additional indirectly fabricated post — same tooth — <i>includes canal preparation</i>	\$25.00
D2954	Prefabricated post and core in addition to crown — <i>base metal post; includes canal preparation</i>	\$20.00
D2957	Each additional prefabricated post — same tooth — <i>base metal post; includes canal preparation</i>	\$15.00
D2970	Temporary crown (fractured tooth) — <i>palliative treatment only</i>	\$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$28.00
D2980	Crown repair, by report	\$15.00

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	\$10.00
D3230	Pulpal therapy (resorbable filling) — anterior, primary tooth (excluding final restoration)	\$20.00
D3240	Pulpal therapy (resorbable filling) — posterior, primary tooth (excluding final restoration)	\$20.00
D3310	Root canal — anterior (excluding final restoration)	\$55.00
D3320	Root canal — bicuspid (excluding final restoration)	\$120.00
D3330	Root canal — molar (excluding final restoration)	\$250.00
D3331	Treatment of root canal obstruction; non-surgical access	\$55.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$55.00
D3333	Internal root repair of perforation defects	\$55.00
D3346	Retreatment of previous root canal therapy — anterior	\$85.00
D3347	Retreatment of previous root canal therapy — bicuspid	\$150.00
D3348	Retreatment of previous root canal therapy — molar	\$280.00
D3351	Apexification/recalcification — initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	\$75.00
D3352	Apexification/recalcification — interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$50.00
D3353	Apexification/recalcification — final visit (includes completed root canal therapy — apical closure/ calcific repair of perforations, root resorption, etc.)	\$50.00
D3410	Apicoectomy/periradicular surgery — anterior	\$60.00
D3421	Apicoectomy/periradicular surgery — bicuspid (first root)	\$70.00
D3425	Apicoectomy/periradicular surgery — molar (first root)	\$80.00
D3426	Apicoectomy/periradicular surgery (each additional root)	\$50.00
D3430	Retrograde filling — per root	\$60.00
D3450	Root amputation, per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	\$30.00

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 teeth spaces per quadrant	\$130.00
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant	\$80.00
D4240	Gingival flap procedure, including root planing — four or more contiguous teeth or bounded teeth spaces per quadrant	\$130.00

Code	Description	Enrollee Pays
D4241	Gingival flap procedure, including root planing — one to three contiguous teeth or bounded teeth spaces per quadrant	\$80.00
D4245	Apically positioned flap	\$125.00
D4249	Clinical crown lengthening — hard tissue	\$125.00
D4260	Osseous surgery (including flap entry and closure) — four or more contiguous teeth or bounded teeth spaces per quadrant	\$280.00
D4261	Osseous surgery (including flap entry and closure) — one to three contiguous teeth or bounded teeth spaces per quadrant	\$225.00
D4263	Bone replacement graft — first site in quadrant	\$205.00
D4264	Bone replacement graft — each additional site in quadrant	\$70.00
D4270	Pedicle soft tissue graft procedure	\$205.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$205.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$45.00
D4341	Periodontal scaling and root planing — four or more teeth per quadrant — <i>limited to 4 quadrants during any 12 consecutive months</i>	\$25.00
D4342	Periodontal scaling and root planing — one to three teeth per quadrant — <i>limited to 4 quadrants during any 12 consecutive months</i>	\$20.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis — <i>limited to 1 treatment in any 12 consecutive months</i>	\$25.00
D4910	Periodontal maintenance — <i>limited to 1 treatment each 6 month period</i>	\$15.00
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i>	\$55.00

D5000-D5899 VI. PROSTHODONTICS (removable)

— For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

— Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive

— Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture — maxillary	\$145.00
D5120	Complete denture — mandibular	\$145.00
D5130	Immediate denture — maxillary	\$165.00
D5140	Immediate denture — mandibular	\$165.00
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests and teeth)	\$120.00
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests and teeth)	\$120.00
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$160.00
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$160.00
D5225	Maxillary partial denture — flexible base (including any clasps, rests and teeth)	\$210.00
D5226	Mandibular partial denture — flexible base (including any clasps, rests and teeth)	\$210.00
D5410	Adjust complete denture — maxillary	\$10.00
D5411	Adjust complete denture — mandibular	\$10.00
D5421	Adjust partial denture — maxillary	\$10.00
D5422	Adjust partial denture — mandibular	\$10.00
D5510	Repair broken complete denture base	\$20.00
D5520	Replace missing or broken teeth — complete denture (each tooth)	\$10.00
D5610	Repair resin denture base	\$20.00
D5620	Repair cast framework	\$20.00

Code	Description	Enrollee Pays
D5630	Repair or replace broken clasp	\$20.00
D5640	Replace broken teeth — per tooth	\$10.00
D5650	Add tooth to existing partial denture	\$10.00
D5660	Add clasp to existing partial denture	\$10.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$135.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$135.00
D5710	Rebase complete maxillary denture	\$55.00
D5711	Rebase complete mandibular denture	\$55.00
D5720	Rebase maxillary partial denture	\$55.00
D5721	Rebase mandibular partial denture	\$55.00
D5730	Reline complete maxillary denture (chairside)	\$20.00
D5731	Reline complete mandibular denture (chairside)	\$20.00
D5740	Reline maxillary partial denture (chairside)	\$20.00
D5741	Reline mandibular partial denture (chairside)	\$20.00
D5750	Reline complete maxillary denture (laboratory)	\$60.00
D5751	Reline complete mandibular denture (laboratory)	\$60.00
D5760	Reline maxillary partial denture (laboratory)	\$60.00
D5761	Reline mandibular partial denture (laboratory)	\$60.00
D5820	Interim partial denture (maxillary) — limited to 1 in any 12 consecutive months	\$75.00
D5821	Interim partial denture (mandibular) — limited to 1 in any 12 consecutive months	\$75.00
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	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]).		
— When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per unit, beyond the 6th unit.		
— Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.		
D6210	Pontic — cast high noble metal	\$210.00
D6211	Pontic — cast predominantly base metal	\$110.00
D6212	Pontic — cast noble metal	\$150.00
D6240	Pontic — porcelain fused to high noble metal	\$240.00
D6241	Pontic — porcelain fused to predominantly base metal	\$140.00
D6242	Pontic — porcelain fused to noble metal	\$180.00
D6245	Pontic — porcelain/ceramic	\$240.00
D6250	Pontic — resin with high noble metal	\$195.00
D6251	Pontic — resin with predominantly base metal	\$95.00
D6252	Pontic — resin with noble metal	\$135.00
D6600	Inlay — porcelain/ceramic, two surfaces	\$190.00
D6601	Inlay — porcelain/ceramic, three or more surfaces	\$200.00
D6602	Inlay — cast high noble metal, two surfaces	\$100.00
D6603	Inlay — cast high noble metal, three or more surfaces	\$100.00
D6604	Inlay — cast predominantly base metal, two surfaces	No Cost
D6605	Inlay — cast predominantly base metal, three or more surfaces	No Cost
D6606	Inlay — cast noble metal, two surfaces	\$40.00
D6607	Inlay — cast noble metal, three or more surfaces	\$40.00
D6608	Onlay — porcelain/ceramic, two surfaces	\$185.00
D6609	Onlay — porcelain/ceramic, three or more surfaces	\$205.00
D6610	Onlay — cast high noble metal, two surfaces	\$100.00
D6611	Onlay — cast high noble metal, three or more surfaces	\$100.00
D6612	Onlay — cast predominantly base metal, two surfaces	No Cost
D6613	Onlay — cast predominantly base metal, three or more surfaces	No Cost
D6614	Onlay — cast noble metal, two surfaces	\$40.00
D6615	Onlay — cast noble metal, three or more surfaces	\$40.00
D6720	Crown — resin with high noble metal	\$195.00
D6721	Crown — resin with predominantly base metal	\$95.00
D6722	Crown — resin with noble metal	\$135.00
D6740	Crown — porcelain/ceramic	\$240.00
D6750	Crown — porcelain fused to high noble metal	\$240.00
D6751	Crown — porcelain fused to predominantly base metal	\$140.00

Code	Description	Enrollee Pays
D6752	Crown — porcelain fused to noble metal	\$180.00
D6780	Crown — 3/4 cast high noble metal	\$210.00
D6781	Crown — 3/4 cast predominantly base metal	\$110.00
D6782	Crown — 3/4 cast noble metal	\$150.00
D6783	Crown — 3/4 porcelain/ceramic	\$240.00
D6790	Crown — full cast high noble metal	\$210.00
D6791	Crown — full cast predominantly base metal	\$110.00
D6792	Crown — full cast noble metal	\$150.00
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated — includes canal preparation	\$35.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer — base metal post; includes canal preparation	\$20.00
D6973	Core buildup for retainer, including any pins	\$15.00
D6976	Each additional indirectly fabricated post — same tooth — includes canal preparation	\$25.00
D6977	Each additional prefabricated post — same tooth — base metal post; includes canal preparation	\$15.00
D6980	Fixed partial denture repair, by report	\$15.00
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY		
<i>Includes preoperative and postoperative evaluations and treatment under a local anesthetic.</i>		
D7111	Extraction, coronal remnants — deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$5.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$25.00
D7220	Removal of impacted tooth — soft tissue	\$50.00
D7230	Removal of impacted tooth — partially bony	\$70.00
D7240	Removal of impacted tooth — completely bony	\$90.00
D7241	Removal of impacted tooth — completely bony, with unusual surgical complications	\$110.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$85.00
D7280	Surgical access of an unerupted tooth	\$90.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	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	\$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	\$70.00
D7321	Alveoloplasty not in conjunction with extractions — one to three teeth or tooth spaces, per quadrant	\$70.00
D7450	Removal of benign odontogenic cyst or tumor — lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor — lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess — intraoral soft tissue	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) — separate procedure	No Cost
D7970	Excision of hyperplastic tissue — per arch	\$55.00
D7971	Excision of pericoronal gingiva	\$55.00

Code	Description	Enrollee Pays
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D8000-D8999 XI. ORTHODONTICS

— The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.

— The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and

diagnostic services includes: \$200.00

D0210 Intraoral — complete series (including bitewings)

D0322 Tomographic survey

D0330 Panoramic film

D0340 Cephalometric film

D0350 Oral/facial photographic images

D0470 Diagnostic casts

The benefit for post-treatment records includes: \$70.00

D0210 Intraoral — complete series (including bitewings)

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition . . . \$950.00

D8020 Limited orthodontic treatment of the transitional dentition

— child or adolescent to age 19 \$950.00

D8030 Limited orthodontic treatment of the adolescent dentition

— adolescent to age 19 \$950.00

D8040 Limited orthodontic treatment of the adult dentition —

adults, including covered dependent adult children \$1,150.00

D8050 Interceptive orthodontic treatment of the primary dentition \$950.00

D8060 Interceptive orthodontic treatment of the transitional

dentition \$950.00

D8070 Comprehensive orthodontic treatment of the transitional

dentition — child or adolescent to age 19 \$1,700.00

D8080 Comprehensive orthodontic treatment of the adolescent

dentition — adolescent to age 19 \$1,700.00

D8090 Comprehensive orthodontic treatment of the adult dentition

— adults, including covered dependent adult children . . . \$1,900.00

D8660 Pre-orthodontic treatment visit \$25.00

D8680 Orthodontic retention (removal of appliances, construction

and placement of removable retainers) \$275.00

D8999 Unspecified orthodontic procedure, by report — includes

treatment planning session \$100.00

Code	Description	Enrollee Pays
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D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain —

minor procedure \$5.00

D9211 Regional block anesthesia No Cost

D9212 Trigeminal division block anesthesia No Cost

D9215 Local anesthesia No Cost

D9220 Deep sedation/general anesthesia — first 30 minutes . . . \$165.00

D9221 Deep sedation/general anesthesia — each additional

15 minutes \$80.00

D9241 Intravenous conscious sedation/analgesia —

first 30 minutes \$165.00

D9242 Intravenous conscious sedation/analgesia —

each additional 15 minutes \$80.00

D9310 Consultation — diagnostic service provided by

dentist or physician other than requesting dentist

or physician \$10.00

D9430 Office visit for observation (during regularly scheduled

hours) — no other services performed \$5.00

D9440 Office visit — after regularly scheduled hours \$25.00

D9450 Case presentation, detailed and extensive

treatment planning No Cost

D9940 Occlusal guard, by report — limited to 1 in 3 years \$100.00

D9951 Occlusal adjustment, limited \$35.00

D9952 Occlusal adjustment, complete \$55.00

D9972 External bleaching — per arch — limited to one bleaching

tray and gel for two weeks of self treatment \$125.00

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

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

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.

LIMITATIONS AND EXCLUSIONS OF BENEFITS

SCHEDULE B – LIMITATIONS 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 DeltaCare USA to 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. 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 the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is \$150.00 per molar;
11. 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;
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. 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;
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) or removable partial denture:
 - a. Fixed partial denture (bridge):
 - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved; **or**
 - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics (see Limitation #12); **or**
 - Each abutment tooth to be crowned meets Limitation #8;

- b. Removable partial denture
 - Cast metal (D5213, D5214), one or more teeth are missing in an arch;
 - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #12);
- 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 seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by DeltaCare USA, 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. Soft tissue management programs are 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 other covered services;
- 26. 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;

- 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.

"Filed fee" means the Contract Dentist's fees on file with DeltaCare USA. Questions regarding these fees should be directed to DeltaCare USA'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 Worker's 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 DeltaCare USA's dental consultant:
 - 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 DeltaCare USA or as cited under *Section 4.04*. To obtain written authorization, the Enrollee should call DeltaCare USA's 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 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;
- 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 DeltaCare USA's 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 DeltaCare USA 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 23. 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 the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$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 the Enrollee's 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 orthodontics¹³, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
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.

¹³*Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.*

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*.

DeltaCare USA 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:

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

Administered by



Delta Dental of California
P.O. Box 997330
Sacramento, California 95899-7330
Web site: www.deltadentalca.org

**For questions about
Delta Dental PPO:**
800-765-6003
Monday-Friday, 5 a.m. to 5 p.m. (Pacific time)

**For questions about
DeltaCare USA/DeltaCare USA:**
800-422-4234
Customer Service
Monday-Friday, 5 a.m. to 6 p.m. (Pacific time)
Web site: www.deltadentalca.org