A Prepaid Dental Plan for
UNIVERSITY OF CALIFORNIA
Employees, Retirees, and
Their Dependents

Evidence of Coverage and Disclosure Statement
January 1, 2023

Underwritten by:
Delta Dental of California
18000 Studebaker Road, Suite 350
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

https://www1.deltadentalins.com/group-sites/uc.html
EVIDENCE OF COVERAGE
DISCLOSURE FORM
OF THE DENTAL PROGRAM
FOR ELIGIBLE EMPLOYEES AND RETIREES OF
THE UNIVERSITY OF CALIFORNIA

This Combined Evidence of Coverage and Disclosure Form (“EOC”) provides information about Your DeltaCare USA Dental Health Care Plan (“Plan”) provided by Delta Dental of California (“Company”), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Service Contract with Us.

This document, including the Contract and any attachments, provides the terms and conditions of Your Plan’s coverage. Read this document carefully for an explanation of Your coverage, including the Definitions section for any terms with special or technical meanings.

This Combined EOC and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

A STATEMENT DESCRIBING DELTA DENTAL’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED “SPECIAL NEEDS”.

Terms such as “You,” “Your” and “Yourself” means the individuals who are covered. “We,” “Us” and “Our” refers to the Company or Our Third Party Administrator (“Administrator”).
Identification Card (ID)
ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification (“ID”) number should be provided to Your Dentist. An ID card will may be obtained by visiting Our website at https://www1.deltadentalins.com/group-sites/uc.html.

Contract
The Benefit explanations contained in this EOC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the EOC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act (“ERISA”).

Contact Us
For more information, visit Our website at https://www1.deltadentalins.com/group-sites/uc.html or call the Customer Service at 800-422-4234 or You may submit an inquiry to:

Delta Dental of California (formerly PMI)
18000 Studebaker Road, Suite 530
Cerritos, Ca 90703
800-422-4234

Or contact us on the internet at:
https://www1.deltadentalins.com/group-sites/uc.html

Notice
Please read the following information so that You will know how to obtain dental services.

You must obtain dental Benefits from Your Contract Dentist or be referred for Specialist Services.
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Eligibility, Enrollment and Termination

Eligibility
The University of California establishes its own dental plan eligibility, enrollment and termination criteria based on the “Complete Guide to Your UC Health Benefits” and any corresponding administrative supplements.

Employees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Complete Guide to Your UC Health Benefits.” A copy of this booklet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet (ucnet.universityofcalifornia.edu) to help you with your health and welfare plan decisions.

Retirees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Complete Guide to Your UC Health Benefits.” A copy of the fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet (ucnet.universityofcalifornia.edu) to help you with your health and welfare plan decisions.

Enrollment

Employees
Information pertaining to enrollment can be found in the “Complete Guide to Your UC Health Benefits.” A copy of the fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

Retirees
Information pertaining to your enrollment can be found in the “Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members.” A copy of the fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

Definitions
As used in this booklet:

**ADDITIONAL FEE(S)** means the difference in cost of the covered Benefit and the Usual Fee for Optional treatment.
ADMINISTRATOR means a third party entity designated by Delta Dental to perform administrative functions, including, but not limited to, the collection of premium and eligibility.

BENEFITS mean those dental services which are described in this booklet.

CLIENT means The University of California contracting to obtain Benefits for Eligible Employees.

CONTRACT DENTIST means a Dentist who provides services in general dentistry and has agreed to provide Benefits to Enrollees under this Program.

CONTRACT ORTHODONTIST means a Dentist who specializes in orthodontics and has agreed to provide Benefits to Enrollees under this Program.

CONTRACT SPECIALIST means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

COPAYMENT means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

DENTIST means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

ELIGIBLE DEPENDENT means any dependent (as defined in the Eligibility Section) of an Eligible Employee who is eligible for Benefits as described in this booklet.

ELIGIBLE EMPLOYEE means any employee (as defined in the Eligibility Section) or group member who is eligible for Benefits as described in this booklet.

EMERGENCY DENTAL CONDITION means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, it could reasonably result in any of the following:

• placing the patient's health in serious jeopardy
• serious impairment to bodily functions
• serious dysfunction of any bodily organ or part
• death

EMERGENCY DENTAL SERVICE means a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

ENROLLEE means an Eligible Employee (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.

MEDICALLY NECESSARY GENERAL ANESTHESIA means physical limitations or health conditions that prohibit treatment being rendered under local anesthesia. Such limitations or conditions must be verified in writing by a physician.

OUT-OF-NETWORK means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.
PREAUTHORIZATION means the process by which Delta Dental determines if a procedure or treatment is a referable covered Benefit under the Enrollee’s plan.

SPECIAL HEALTH CARE NEED means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee’s ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee’s inability to obtain access to the assigned Contract Dentist’s facility because of a physical disability and 2) the Enrollee’s inability to comply with the Contract Dentist’s instructions during examination or treatment because of physical disability or mental incapacity.

SPECIALIST SERVICES mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

TREATMENT IN PROGRESS means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

TREATMENT PLAN means the procedures developed by your Contract Dentist to provide dental care for a particular condition.

URGENT DENTAL SERVICES means medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

USUAL FEE means the fee that an individual Dentist most frequently charges for a given service.

WE, US or OUR means Delta Dental of California or the Administrator as appropriate.

General Information
Delta Dental is founded on the principle of delivering quality dental care and preventing dental problems before they start. Dental services are provided solely by your selected DeltaCare USA Contract Dentist. If any services are provided by a non-DeltaCare USA Contract Dentist or specialist, you will be obligated to pay for such services.

How to use the DeltaCare USA Plan – Choice of Contract Dentist
To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. You can also access an online provider directory at https://www1.deltadentalins.com/group-sites/uc.html. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In
order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234. If you cannot keep your appointment, notify the Contract Dentist's office at least 24 hours in advance, or you will be charged for a broken appointment.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN EMERGENCY SERVICES. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

To receive Benefits, other than for out-of-area emergency dental care, service must be rendered by: your assigned DeltaCare USA Contract Dentist; a dental hygienist under his/her supervision; or a specialist to whom your DeltaCare USA Contract Dentist has referred you, and whose treatment has been preauthorized in writing by Delta Dental.

If you have any questions about a prior authorization, please call Delta Dental at the numbers listed on the back page of this booklet.

If your assigned Contract Dentist’s agreement with Delta Dental terminates, that Contract Dentist will complete 1) a partial or full denture for which final impressions have been taken, and 2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

**Continuity of Care**

Current Members:

You may have the right to the benefit of completion of care with your terminated Dentist for certain specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Members:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for
this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law.

**Special Needs**
If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental’s Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

**Facility Accessibility**
Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental’s Customer Service department at 800-422-4234.

**Benefits, Limitations and Exclusions**
This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

**Copayments and Other Charges**
You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

**Emergency Dental Services**
Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the patient’s condition. The Enrollee’s assigned Contract Dentist’s facility maintains a 24 hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, he or she can call 911 (where available) or obtain Emergency Dental Services from any dental provider without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee’s assigned Contract Dentist’s facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee’s financial responsibility and will not be paid by this plan.
Urgent Dental Services Inside the Service Area
An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that he or she may need Urgent Dental Services, the Enrollee can call his or her Contract Dentist.

Out-of-Area Urgent Care
If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, we cover Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:
• The Enrollee receives the Urgent Dental Services from Out-of-Network Dentists while temporarily outside of the Delta Dental Service Area.
• A reasonable person would have believed that the Enrollee’s health would seriously deteriorate if he or she delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services an Enrollee receives from Out-of-Network Dentists are covered if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call his or her Contract Dentist. The Enrollee is responsible for any Copayment(s) for Urgent Dental Services received.

Specialist Services
Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by your assigned Contract Dentist; and 2) authorized by us. You pay the specified Copayment(s). (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered. Delta Dental will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits.

Second Opinion
You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases an Emergency Dental Condition will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For
assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental’s Customer Service department at 800-422-4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist’s facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to the Enrollee Complaint Procedure section for more information.

Claims for Reimbursement
Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation
A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in Emergency Services, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies
The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental’s Customer Service department for assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental’s Customer Service department at 800-422-4234 or write to Delta Dental.
Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

**Coordination of Benefits**

In addition to the provisions under Dental Accident Benefits, this Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:
1) the amount that it would have paid in the absence of any other dental benefit coverage, or
2) the enrollee’s total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this plan.

An Enrollee must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

**Enrollee Complaint Procedure**

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422 4234, or the complaint may be addressed in writing to:

Quality Management Department  
P.O. Box 6050  
Artesia, CA 90703

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist’s name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental for at least 180 days after receipt of the adverse determination. Delta Dental’s review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental
will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition to a patient’s dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental’s grievance process, or you have been involved in Delta Dental’s grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately you are experiencing an Emergency Dental Condition.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-422-4234 and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for Emergency Dental Condition or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.
Public Policy Participation by Enrollees
Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service department, P.O. Box 1803, Alpharetta, GA 30023.

Termination of Benefits
All Benefits terminate for any Enrollee as of the date that this Program is terminated. We are not obligated to continue to provide Benefits to any such person in such event except for completion of single procedures commenced while this Program was in effect.

If you believe that enrollment has been improperly cancelled or not renewed you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to the Enrollee Complaint Procedure section for more information.

Organ and Tissue Donation
Organ and tissue donation provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Timely Access to Care
Contract Dentists, Contract Orthodontists, and Contract Specialists have agreed waiting times to Enrollees for appointments for care will never be greater than the following time frames:

a. For emergency care, 24 hours a day, 7 days a week;

b. For any urgent care, 72 hours for appointments consistent with the patient's individual needs;

c. For any non-urgent care, 36 business days; and

d. For any preventative services, 40 business days.

During non-business hours, the Enrollee will have access to their Provider’s answering machine, answering service, cell phone, or pager for guidance on what to do and who to contact if the Enrollee is calling due to an emergency or urgent care situation.

If an Enrollee calls our plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists and Contract Specialists offices please call 800-422-4234 for assistance.
Non-Discrimination
Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Customer Service Center at 800-471-9925.

If you believe that Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 800-471-9925
Website Address: https://www1.deltadentalins.com/group-sites/uc.html

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

## 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-2023 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 Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100-D0999</td>
<td><strong>I. DIAGNOSTIC</strong></td>
<td></td>
</tr>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation - post-operative visit</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0190</td>
<td>Screening of a patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0191</td>
<td>Assessment of a patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - comprehensive series of radiographic images - limited to 1 series every 12 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0251</td>
<td>Extraoral posterior dental radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings three radiographic images</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four radiographic images - limited to 1 series every 6 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 radiographic images</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0415</td>
<td>Collection of microorganisms for culture and sensitivity</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0419</td>
<td>Assessment of salivary flow by measurement - 1 every 12 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0472</td>
<td>Accession of tissue, gross examination, preparation and transmission of written report</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and transmission of written report</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
D0474  Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report .......................... No Cost
D0601  Caries risk assessment and documentation, with a finding of low risk - 1 every 12 months................................................................. No Cost
D0602  Caries risk assessment and documentation, with a finding of moderate risk - 1 every 12 months ......................................................... No Cost
D0603  Caries risk assessment and documentation, with a finding of high risk - 1 every 12 months ................................................................. No Cost
D0701  Panoramic radiographic image - image capture only ..................... No Cost
D0702  2-D cephalometric radiographic image - image capture only .... No Cost
D0703  2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only ................................................................. No Cost
D0705  Extra-oral posterior dental radiographic image - image capture only........................................................................................................ No Cost
D0706  Intraoral - occlusal radiographic image - image capture only ...... No Cost
D0707  Intraoral - periapical radiographic image - image capture only.. No Cost
D0708  Intraoral - bitewing radiographic image - image capture only .... No Cost
D0709  Intraoral - comprehensive series of radiographic images - image capture only ................................................................................ No Cost
D0999  Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services) ............................................. No Cost

D1000-D1999  II. PREVENTIVE
D1110  Prophylaxis cleaning - adult - 2 D1110, D1120 or D4346 per 12 month period ................................................................. No Cost
D1110  Additional prophylaxis cleaning - adult (within the 12 month period) ................................................................. $45.00
D1120  Prophylaxis cleaning - child - 2 D1110, D1120 or D4346 per 12 month period ................................................................. No Cost
D1120  Additional prophylaxis cleaning - child (within the 12 month period) ................................................................. $35.00
D1206  Topical application of fluoride varnish - child to age 19; 2 D1206 or D1208 per 12 month period ......................................................... No Cost
D1208  Topical application of fluoride - excluding varnish - child to age 19; 2 D1206 or D1208 per 12 month period ......................................................... No Cost
D1310  Nutritional counseling for control of dental disease ........................ No Cost
D1320  Tobacco counseling for the control and prevention of oral disease................................................................. No Cost
D1330  Oral hygiene instructions ........................................................................ No Cost
D1351  Sealant - per tooth - limited to permanent molars through age 15........................................................................................................ No Cost
D1352  Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to permanent molars through age 15........................................................................................................ No Cost
D1353  Sealant repair - per tooth - limited to permanent molars through age 15........................................................................................................ No Cost
D1354  Application of caries arresting medicament - per tooth - child to age 19; 2 per 12 month period ........................................................................ No Cost
D1510  Space maintainer - fixed - unilateral - per quadrant ......................... No Cost
D1516  Space maintainer - fixed - bilateral, maxillary .................................. No Cost
D1517  Space maintainer - fixed - bilateral, mandibular ................................ No Cost
D1520  Space maintainer - removable - unilateral - per quadrant ............... No Cost
D1526  Space maintainer - removable - bilateral, maxillary ........................ No Cost
D1527  Space maintainer - removable - bilateral, mandibular ..................... No Cost
D1551  Re-cement or re-bond bilateral space maintainer - maxillary ...... No Cost
D1552  Re-cement or re-bond bilateral space maintainer - mandibular ........................................................................................................ No Cost
D1553  Re-cement or re-bond unilateral space maintainer -
per quadrant .................................................................................................. No Cost
D1556  Removal of fixed unilateral space maintainer - per quadrant ..... No Cost
D1557  Removal of fixed bilateral space maintainer - maxillary.......... No Cost
D1558  Removal of fixed bilateral space maintainer - mandibular ........ No Cost
D1575  Distal shoe space maintainer - fixed, unilateral -
per quadrant - child to age 9 ................................................................. No Cost

D2000-D2999  III. RESTORATIVE
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
D2140  Amalgam - one surface, primary or permanent........................... No Cost
D2150  Amalgam - two surfaces, primary or permanent ........................ No Cost
D2160  Amalgam - three surfaces, primary or permanent ........................ No Cost
D2161  Amalgam - four or more surfaces, primary or permanent ......... No Cost
D2230  Resin-based composite - one surface, anterior ......................... No Cost
D2231  Resin-based composite - two surfaces, anterior ........................ No Cost
D2232  Resin-based composite - three surfaces, anterior ....................... No Cost
D2235  Resin-based composite - four or more surfaces or involving
incisal angle (anterior) ............................................................................. No Cost
D2290  Resin-based composite crown, anterior ...................................... No Cost
D2291  Resin-based composite - one surface, posterior ........................ $65.00
D2292  Resin-based composite - two surfaces, posterior ....................... $75.00
D2293  Resin-based composite - three surfaces, posterior .................... $85.00
D2294  Resin-based composite - four or more surfaces, posterior .......... $95.00
D2250  Inlay - metallic - one surface ......................................................... No Cost
D2252  Inlay - metallic - two surfaces ...................................................... No Cost
D2253  Inlay - metallic - three or more surfaces ..................................... No Cost
D2242  Onlay - metallic - two surfaces ................................................... No Cost
D2243  Onlay - metallic - three surfaces .................................................. No Cost
D2244  Onlay - metallic - four or more surfaces .................................... No Cost
D2250  Inlay - porcelain/ceramic - one surface ...................................... $200.00
D2252  Inlay - porcelain/ceramic - two surfaces ................................... $250.00
D2253  Inlay - porcelain/ceramic - three or more surfaces ................. $300.00
D2262  Onlay - porcelain/ceramic - two surfaces .................................. $270.00
D2263  Onlay - porcelain/ceramic - three surfaces ............................... $340.00
D2264  Onlay - porcelain/ceramic - four or more surfaces ................. $370.00
D2265  Inlay - resin-based composite - one surface .............................. $100.00
D2261  Inlay - resin-based composite - two surfaces ......................... $150.00
D2262  Inlay - resin-based composite - three or more surfaces .......... $200.00
D2263  Onlay - resin-based composite - two surfaces ......................... $150.00
D2264  Onlay - resin-based composite - three surfaces ...................... $200.00
D2265  Onlay - resin-based composite - four or more surfaces .......... $250.00
D2270  Crown - resin-based composite (indirect) ................................ $50.00
D2271  Crown - 3/4 resin-based composite (indirect) ............................ $50.00
D2272  Crown - resin with high noble metal ....................................... $150.00
D2272  Crown - resin with predominantly base metal ....................... $50.00
D2272  Crown - resin with noble metal ............................................... $50.00
D2274  Crown - porcelain/ceramic ......................................................... $50.00
D2275  Crown - porcelain fused to high noble metal ......................... $150.00
D2271  Crown - porcelain fused to predominantly base metal ............ $50.00
D2272  Crown - porcelain fused to noble metal ................................. $50.00
D2273  Crown - porcelain fused to titanium and titanium alloys .......... $150.00
D2280  Crown - 3/4 cast high noble metal ............................................. $150.00
D2281  Crown - 3/4 cast predominantly base metal ............................. $50.00
D2282  Crown - 3/4 cast noble metal ..................................................... $50.00
D2283  Crown - 3/4 porcelain/ceramic ................................................... $50.00
D2290  Crown - full cast high noble metal ............................................ $150.00
D2791  Crown - full cast predominantly base metal ...............................$50.00
D2792  Crown - full cast noble metal ..............................................$50.00
D2794  Crown - titanium and titanium alloys .................................$50.00
D2910  Re-cement or re-bond inlay, onlay, veneer or partial
coverage restoration ........................................................................ No Cost
D2915  Re-cement or re-bond indirectly fabricated or prefabricated
post and core ...................................................................................... No Cost
D2920  Re-cement or re-bond crown ........................................................................ No Cost
D2921  Retachment of tooth fragment, incisal edge or
cusp (anterior) ...................................................................................... No Cost
D2927  Prefabricated porcelain/ceramic crown - permanent tooth ....... No Cost
D2928  Prefabricated porcelain/ceramic crown - primary tooth - anterior ...................................................................................... No Cost
D2930  Prefabricated stainless steel crown - primary tooth .................. No Cost
D2931  Prefabricated stainless steel crown - permanent tooth ............ No Cost
D2932  Prefabricated resin crown - anterior primary tooth .................. No Cost
D2933  Prefabricated stainless steel crown with resin window - anterior primary tooth ........................................................................ No Cost
D2940  Protective restoration ........................................................................ No Cost
D2941  Interim therapeutic restoration - primary dentition ......................... No Cost
D2949  Restorative foundation for an indirect restoration ........................ No Cost
D2950  Core buildup, including any pins when required ........................ No Cost
D2951  Pin retention - per tooth, in addition to restoration ......................... No Cost
D2952  Post and core in addition to crown, indirectly fabricated -
includes canal preparation 2 ........................................................................ No Cost
D2953  Each additional indirectly fabricated post - same tooth -
includes canal preparation 2 ........................................................................ No Cost
D2954  Prefabricated post and core in addition to crown -
base metal post; includes canal preparation ................................................. No Cost
D2956  Each additional prefabricated post - same tooth -
base metal post; includes canal preparation ................................................. No Cost
D2957  Additional procedures to customize a crown to fit under
an existing partial denture framework ...................................................... $10.00
D2980  Crown repair necessitated by restorative material failure ............. No Cost
D2981  Inlay repair necessitated by restorative material failure ................ No Cost
D2982  Onlay repair necessitated by restorative material failure ............. No Cost
D2983  Veneer repair necessitated by restorative material failure ........... No Cost
D2990  Resin infiltration of incipient smooth surface lesions -
limited to permanent molars through age 15 ................................................. No Cost

D3000-D3999  IV. ENDODONTICS

D3110  Pulp cap - direct (excluding final restoration) .............................. No Cost
D3120  Pulp cap - indirect (excluding final restoration) ............................. No Cost
D3220  Therapeutic pulpotomy (excluding final restoration) -
removal of pulp coronal to the dentinocemental junction
and application of medicament ............................................................... No Cost
D3221  Pulpal debridement, primary and permanent teeth ..................... No Cost
D3222  Partial pulpotomy for apexogenesis - permanent tooth with
incomplete root development .................................................................. No Cost
D3230  Pulpal therapy (resorbable filling) - anterior, primary tooth
(excluding final restoration) .................................................................. No Cost
D3240  Pulpal therapy (resorbable filling) - posterior, primary tooth
(excluding final restoration) .................................................................. No Cost
D3310  Root canal - endodontic therapy, anterior tooth
(excluding final restoration) 3 .................................................................... $20.00
D3320  Root canal - endodontic therapy, premolar tooth
(excluding final restoration) 3 .................................................................... $40.00
D3330  Root canal - endodontic therapy, molar tooth (excluding final restoration) .............................................. $60.00
D3331  Treatment of root canal obstruction; non-surgical access .......... $45.00
D3332  Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth .............................................................................................................. $45.00
D3333  Internal root repair of perforation defects .............................................. $45.00
D3346  Retreatment of previous root canal therapy - anterior ........................ $20.00
D3347  Retreatment of previous root canal therapy - premolar ................ $40.00
D3348  Retreatment of previous root canal therapy - molar ........................ $60.00
D3351  Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) .......... $70.00
D3352  Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) .............................................................. $45.00
D3353  Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) .............................................................. $45.00
D3410  Apicoectomy - anterior ....................................................................................................................... No Cost
D3421  Apicoectomy - premolar (first root) ........................................................................................................ No Cost
D3425  Apicoectomy - molar (first root) ............................................................................................................. No Cost
D3426  Apicoectomy (each additional root) ................................................................................................... No Cost
D3430  Retrograde filling - per root ................................................................................................................. No Cost
D3450  Root amputation, per root - not covered in conjunction with a hemisection ................................................................. No Cost
D3471  Surgical repair of root resorption - anterior ................................................................. No Cost
D3472  Surgical repair of root resorption - premolar ................................................................. No Cost
D3473  Surgical repair of root resorption - molar ................................................................. No Cost
D3501  Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior ................................................................. No Cost
D3502  Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar ................................................................. No Cost
D3503  Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ................................................................. No Cost

D4000-D4999  V. PERIODONTICS
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D4210  Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant ........................................ No Cost
D4211  Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant ........................................ No Cost
D4212  Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth ................................................................. No Cost
D4240  Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant ........................................ No Cost
D4241  Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant ........................................ No Cost
D4260  Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant ....................................................................................... $100.00
D4261  Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant ....................................................................................... $100.00
D4270  Pedicle soft tissue graft procedure ................................................................................................. $150.00
D4277  Free soft tissue graft procedure (including recipient and
donor surgical sites) first tooth, implant, or edentulous
tooth position in graft ................................................................. $150.00

D4278  Free soft tissue graft procedure (including recipient and
donor surgical sites) each additional contiguous tooth,
implant, or edentulous tooth position in same graft site ........... $150.00

D4341  Periodontal scaling and root planing - four or more teeth
per quadrant - limited to 5 quadrants during any
12 consecutive months ............................................................. No Cost

D4342  Periodontal scaling and root planing - one to three teeth
per quadrant - limited to 5 quadrants during any
12 consecutive months ............................................................. No Cost

D4346  Scaling in presence of generalized moderate or severe
gingival inflammation - full mouth, after oral evaluation -
2 D1110, D1120 or D4346 per 12 month period ....................... No Cost

D4355  Full mouth debridement to enable a comprehensive
periodontal evaluation and diagnosis on a subsequent visit -
limited to 1 treatment in any 12 consecutive months ............... No Cost

D4910  Periodontal maintenance - limited to 1 treatment each
6 month period ........................................................................ No Cost

D4910  Additional periodontal maintenance
(within the 6 month period) ..................................................... $55.00

D4921  Gingival irrigation with a medicinal agent - per quadrant .... No Cost

D5000-D5899  VI. PROSTHODONTICS (removable)

D5110  Complete denture - maxillary 5, 6 ........................................ $65.00
D5120  Complete denture - mandibular 5, 6 ................................. $65.00
D5130  Immediate denture - maxillary 5, 6 ................................. $65.00
D5140  Immediate denture - mandibular 5, 6 ............................... $65.00
D5211  Maxillary partial denture - resin base (including
retentive/clasping materials, rests, and teeth) 5, 6 .................... $65.00
D5212  Mandibular partial denture - resin base (including
retentive/clasping materials, rests, and teeth) 5, 6 .................... $65.00
D5213  Maxillary partial denture - cast metal framework with resin
denture bases (including retentive/clasping materials,
rests and teeth) 5, 6 ................................................................. $65.00
D5214  Mandibular partial denture - cast metal framework
with resin denture bases (including retentive/clasping materials,
rests and teeth) 5, 6 ................................................................. $65.00
D5221  Immediate maxillary partial denture - resin base
(including retentive/clasping materials, rests, and teeth) ........... $65.00
D5222  Immediate mandibular partial denture - resin base
(including retentive/clasping materials, rests, and teeth) ........... $65.00
D5223  Immediate maxillary partial denture - cast metal framework
with resin denture bases (including retentive/clasping
materials, rests and teeth) ....................................................... $65.00
D5224  Immediate mandibular partial denture - cast metal framework
with resin denture bases (including retentive/clasping
materials, rests and teeth) ....................................................... $65.00
D5225  Maxillary partial denture - flexible base (including
retentive/clasping materials, rests, and teeth) - prosthetic
appliances will be replaced only after five years have elapsed
from the time of delivery 5, 6 ................................................... $115.00
D5226  Mandibular partial denture - flexible base (including
retentive/clasping materials, rests, and teeth) 5, 6 ............... $115.00
D5227  Immediate maxillary partial denture - flexible base
(including any clasps, rests and teeth) ...................................... $65.00
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5228</td>
<td>Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)</td>
<td>$65.00</td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxiblery</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5621</td>
<td>Repair cast partial framework, mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5622</td>
<td>Repair cast partial framework, maxiblery</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken retentive/clasping materials - per tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture - per tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
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<td>D5720</td>
<td>Rebase maxillary partial denture</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5725</td>
<td>Rebase hybrid prosthesis</td>
<td>$20.00</td>
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<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>No Cost</td>
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<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
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</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
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</tr>
<tr>
<td>D5765</td>
<td>Soft liner for complete or partial removable denture - indirect</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5820</td>
<td>Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5821</td>
<td>Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
<td>No Cost</td>
</tr>
</tbody>
</table>

**D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

**D6000-D6199 VIII. IMPLANT SERVICES - Optional**

Optional implant services - Subject to Limitation #12

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>D6205</td>
<td>Pontic - indirect resin based composite</td>
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<td>Pontic - titanium and titanium alloys</td>
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<td>Pontic - porcelain fused to high noble metal</td>
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<td>Pontic - porcelain fused to noble metal</td>
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<td>Pontic - porcelain fused to titanium and titanium alloys</td>
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<td>Pontic - porcelain/ceramic</td>
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<td>D6250</td>
<td>Pontic - resin with high noble metal</td>
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</tr>
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<td>Pontic - resin with predominantly base metal</td>
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<tr>
<td>D6252</td>
<td>Pontic - resin with noble metal</td>
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<td>Retainer inlay - porcelain/ceramic, two surfaces</td>
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<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
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<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
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<td>D6607</td>
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<td>Retainer onlay - cast predominantly base metal, two surfaces</td>
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<tr>
<td>D6613</td>
<td>Retainer onlay - cast predominantly base metal, three or more surfaces</td>
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</tr>
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<td>D6614</td>
<td>Retainer onlay - cast noble metal, two surfaces</td>
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<td>D6615</td>
<td>Retainer onlay - cast noble metal, three or more surfaces</td>
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<td>D6710</td>
<td>Retainer crown - indirect resin based composite</td>
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<td>D6780</td>
<td>Retainer crown - 3/4 cast high noble metal</td>
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<td>D6782</td>
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</tr>
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<td>Retainer crown 3/4 - titanium and titanium alloys</td>
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</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal</td>
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<tr>
<td>D6791</td>
<td>Retainer crown - full cast predominantly base metal</td>
<td>12</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown - full cast noble metal</td>
<td>12</td>
</tr>
<tr>
<td>D6794</td>
<td>Retainer crown - titanium and titanium alloys</td>
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</tr>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
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<tr>
<td>D6940</td>
<td>Stress breaker</td>
<td>12</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair necessitated by restorative material failure</td>
<td></td>
</tr>
</tbody>
</table>
D7000-D7999  X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111  Extraction, coronal remnants - primary tooth ........................................... No Cost

D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ......................................................................................................................... No Cost

D7210  Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated ........................................................................... No Cost

D7220  Removal of impacted tooth - soft tissue ........................................................................... $15.00

D7230  Removal of impacted tooth - partially bony........................................................................... $15.00

D7240  Removal of impacted tooth - completely bony ................................................................... $15.00

D7241  Removal of impacted tooth - completely bony, with unusual surgical complications ....................................................................................................................... $15.00

D7250  Removal of residual tooth roots (cutting procedure) ................................................... No Cost

D7251  Coronectomy - intentional partial tooth removal, impacted teeth only ................................................................. $15.00

D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth ................................................................................................................................. $50.00

D7280  Exposure of an unerupted tooth ......................................................................................... No Cost

D7282  Mobilization of erupted or malpositioned tooth to aid eruption .................................................................................................................. $85.00

D7283  Placement of device to facilitate eruption of impacted tooth ........................................ No Cost

D7286  Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures ................................................................................................................................. No Cost

D7310  Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ......................................................................................... No Cost

D7311  Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ........................................................................................................ No Cost

D7320  Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ......................................................................................... No Cost

D7321  Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ......................................................................................... No Cost

D7410  Excision of benign lesion up to 1.25 cm ................................................................................. No Cost

D7411  Excision of benign lesion greater than 1.25 cm ......................................................................... No Cost

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

D7460  Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm ................................................................................................................................. No Cost

D7461  Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm ................................................................................................................................. No Cost

D7470  Removal of lateral exostosis (maxilla or mandible) - per site ........................................ No Cost

D7472  Removal of torus palatinus ........................................................................................................ No Cost

D7473  Removal of torus mandibularis ........................................................................................................ No Cost

D7509  Marsupialization of odontogenic cyst ................................................................................................. No Cost

D7510  Incision and drainage of abscess - intraoral soft tissue ................................................................. No Cost

D7880  Occlusal orthotic device, by report - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction ................................................................................................. No Cost

D7881  Occlusal orthotic device adjustment - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction ................................................................................................. No Cost

D7922  Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site ................................................................................................................................. No Cost

D7961  Buccal/labial frenectomy (frenulectomy) ................................................................................................. No Cost
D7962 Lingual frenectomy (frenulectomy) .......................................................... No Cost
D7970 Excision of hyperplastic tissue - per arch .............................................. $50.00
D7971 Excision of pericoronal gingiva ............................................................... $50.00

D8000-D8999 XI. ORTHODONTICS

Pre and post orthodontic records include:

*The benefit for pre-treatment records and diagnostic services includes: ........................................................ No Cost*

- D0210 Intraoral - complete series of radiographic images
- D0322 Tomographic survey
- D0330 Panoramic radiographic image
- D0340 2D cephalometric radiographic image - acquisition, measurement and analysis
- D0350 2D oral/facial photographic images obtained intraorally or extraorally
- D0470 Diagnostic casts

*The benefit for post-treatment records includes: ........................................... No Cost*

- D0210 Intraoral - complete series of radiographic images
- D0470 Diagnostic casts

- D8010 Limited orthodontic treatment of the primary dentition .................... $910.00
- D8020 Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19* .......................................................... $990.00
- D8030 Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19* .......................................................... $1,160.00
- D8040 Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* .................. $1,175.00
- D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* ................................. $1,000.00
- D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* ........................................... $1,000.00
- D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* ...................... $1,000.00
- D8660 Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* .............................................. No Cost
- D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ........................................... No Cost
- D8681 Removable orthodontic retainer adjustment ........................................ No Cost
- D8999 Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding* ........................................ No Cost

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

- D9110 Palliative treatment of dental pain - per visit ...................................... No Cost
- D9211 Regional block anesthesia ................................................................. No Cost
- D9212 Trigeminal division block anesthesia .................................................. No Cost
- D9215 Local anesthesia in conjunction with operative or surgical procedures .......................................................................................... No Cost
- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia ................................................................................ No Cost
D9222 Deep sedation/general anesthesia - first 15 minutes - 
limitations apply. Refer to Schedule B, Limitation #10 ................. No Cost
D9223 Deep sedation/general anesthesia - each subsequent 
15 minute increment - limitations apply. Refer to Schedule B, 
Limitation #10 .................................................................................. No Cost
D9239 Intravenous moderate (conscious) sedation/analgesia - first 
15 minutes - limitations apply. Refer to Schedule B, 
Limitation #10 .................................................................................. No Cost
D9243 Intravenous moderate (conscious) sedation/analgesia - each 
subsequent 15 minute increment - limitations apply. Refer to 
Schedule B, Limitation #10 .................................................................. No Cost
D9310 Consultation - diagnostic service provided by dentist or 
physician other than requesting dentist or physician................. No Cost
D9311 Consultation with a medical health care professional ............ No Cost
D9430 Office visit for observation (during regularly scheduled 
hours) - no other services performed .................................................... No Cost
D9440 Office visit - after regularly scheduled hours ......................... $20.00
D9450 Case presentation, subsequent to detailed and extensive 
treatment planning .............................................................................. No Cost
D9912 Pre-visit patient screening ............................................................... $0.00
D9932 Cleaning and inspection of removable complete 
denture, maxillary .............................................................................. No Cost
D9933 Cleaning and inspection of removable complete 
denture, mandibular........................................................................... No Cost
D9934 Cleaning and inspection of removable partial 
denture, maxillary .............................................................................. No Cost
D9935 Cleaning and inspection of removable partial 
denture, mandibular........................................................................... No Cost
D9943 Occlusal guard adjustment ................................................................ No Cost
D9944 Occlusal guard - hard appliance, full arch - occlusal orthotic 
device and guards are a covered benefit only for the 
treatment of temporomandibular joint (TMJ) dysfunction ............ No Cost
D9945 Occlusal guard - soft appliance, full arch - occlusal orthotic 
device and guards are a covered benefit only for the 
treatment of temporomandibular joint (TMJ) dysfunction ............ No Cost
D9946 Occlusal guard - hard appliance, partial arch - occlusal 
orthotic device and guards are a covered benefit only for the 
treatment of temporomandibular joint (TMJ) dysfunction .... No Cost
D9951 Occlusal adjustment, limited - a covered benefit only for 
the treatment of temporomandibular joint (TMJ) dysfunction .... No Cost
D9952 Occlusal adjustment, complete - a covered benefit only for 
the treatment of temporomandibular joint (TMJ) dysfunction .... No Cost
D9975 External bleaching for home application, per arch; includes 
materials and fabrication of custom trays - limited to one 
bleaching tray and gel for two weeks of self-treatment .......... $125.00
D9986 Missed appointment - without 24 hour notice - per 15 minutes 
of appointment time - up to an overall maximum of $40.00 .... $10.00
D9987 Canceled appointment - without 24 hour notice - per 15 
minutes of appointment time - up to an overall maximum 
of $40.00 .................................................................................................. $10.00
D9990 Certified translation or sign-language services - per visit .... No Cost
D9991 Dental case management - addressing appointment 
compliance barriers ............................................................................. No Cost
D9992 Dental case management - care coordination ......................... No Cost
D9995 Teledentistry - synchronous; real-time encounter .................... No Cost
Procedures with age restrictions will be subject to exceptions based on medical necessity.

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

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

3 A Benefit for permanent teeth only.

4 Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.

5 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.

6 Replacement is subject to a limitation requiring the existing denture to be 3+ years old.

7 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. Optional treatment does not apply when alternative choices are benefits. "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.

8 Listed Copayment covers up to 36 months of active orthodontic treatment excluding the services listed for D8999 “Start-up fee.” Beyond 36 months of active treatment, an additional monthly fee of $75.00 applies.

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

10 Includes adjustments and/or office visits up to 36 months. After 36 months, a monthly fee of $75.00 applies.

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

12 Replacement is subject to a limitation requiring the existing bridge to be 3+ years old.
Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

**Limitations of Benefits**

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.

2. 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.

3. 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.

4. 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 three or more years prior to its replacement, **or**
      - If an existing partial denture is less than three 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.

5. A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the patient's oral health and general dental condition permits.

   Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment.

   Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, it is considered Optional treatment.

   Replacement of an existing nonfunctional bridge is limited to once in a three year period and shall be covered only when the replacement duplicates the original bridge.

   Fixed bridges are not a benefit for Enrollees under the age of 16. A fixed bridge under these circumstances is considered Optional dental treatment.

   Optional treatment procedures are defined under Limitation #9.
6. 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.

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

8. In cases of accidental injury, benefits available are described in Schedule B, Dental Accident Benefits. 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.

9. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist’s “filed fee” for the Optional procedure and the “filed fees” for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits.

10. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

11. The Contract Dentist shall have the right to refuse treatment to an Enrollee who continually fails to follow a prescribed course of treatment.

12. If implants are utilized, Delta Dental will allow the cost of a standard full or partial denture toward the cost of appliances constructed thereon (Optional treatment formula). The patient is responsible for the Optional treatment fee if implants are used. The DeltaCare USA Plan does not cover the surgical removal of implants.

13. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on a maximum of $1,400.00 for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

Should this Contract be terminated by either party due to breach or non-renewal at the end of any applicable term, the provision of the above paragraph shall apply with respect to an Enrollee being treated for orthodontic work which is not completed at the date of termination. The Enrollee’s payment shall be no more than $1,000.00.
14. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, and continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. An enrollee and/or dependent who has had only models taken or has not been banded is not considered to be in active treatment. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

15. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist’s usual fee.

16. 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.

"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. 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.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

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

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

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, unless qualified for the orthodontic treatment in progress limitation 14.

7. Prescription drugs.

8. Dental services received from any dental facility other than a Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Contract and/or Evidence of Coverage.


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

11. Procedures, appliances (other than an occlusal orthotic device) or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

12. 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.

13. 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.
14. 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.

15. Services and benefits provided by the Employee, or any eligible family member, or by the spouse, child, brother, sister, parent, or other relative of the Employee, spouse, or other dependents.

16. Lost, stolen or broken orthodontic appliances.

17. Retreatment of orthodontic cases.

18. Changes in orthodontic treatment necessitated by accident of any kind.


20. Myofunctional therapy.


22. Composite or ceramic brackets, lingual adaptation of orthodontic bands.

23. Transfer after banding has been initiated.

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

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

**Temporomandibular Joint Benefit**

Delta Dental will pay 100% of the Dentist's usual fees or of the fees actually charged for all covered temporomandibular joint (TMJ) procedures, as noted herein. TMJ benefits are intended only for the treatment of temporomandibular (jaw) joint and are limited to the procedures noted below when provided by a licensed dentist as necessary and customary according to the standards of generally accepted dental practice and only when provided for the treatment of TMJ dysfunction:

- D7880 Occlusal orthotic device, by report
- D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
- D9944, D9945, D9946, Occlusal guards
- D9951 Occlusal adjustment - limited
- D9952 Occlusal adjustment - complete
Limitations and Exclusions of TMJ Benefits

TMJ benefits are subject to Schedule B, Limitations and Exclusions of Benefits, and any definitions and/or other terms of the DeltaCare USA Group Dental Service Contract not in conflict with the express terms of this benefit in addition to the following:

1. The replacement of lost, missing or stolen appliances furnished in whole or in part under this benefit or any other TMJ benefit are not covered.

2. Repair and replacement of covered TMJ devices may be made only after three years have elapsed following any prior provision of such appliances under this program or any other program, except when it is determined that there is such extensive change in the patient’s condition (such as the loss of a tooth or teeth) that the appliance cannot be made functional. If the TMJ device is not functional resulting from abuse or alteration by the enrollee, this benefit is excluded.

3. Fixed appliances and restorations provided solely for the treatment of TMJ are excluded.

   **Note:** an occlusal orthotic device is a removable appliance (not “fixed”). Fixed appliances, like fixed partial dentures or crowns placed for the treatment of TMJ, would be excluded.

4. Diagnostic procedures not otherwise covered under the Group Dental Service Contract are excluded.

5. Services for bruxism (grinding of teeth) unrelated to TMJ dysfunction are not covered.

Dental Accident Benefits

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.

Dental Accident is an external blow or other trauma (fall, fist, car accident, gunshot wound, etc.) that would cause severe damage to the dentition, or an internal accident such as biting into glass or a stone that causes severe tooth damage.

Services necessary as a result of a Dental Accident may be covered as primary under your medical coverage. All claims should first be submitted to your medical carrier for review and possible payment, prior to submitting them under the DeltaCare USA plan.

Your medical plan’s customer service representatives will be able to confirm the coverage for Dental Accidents that your medical plan provides.

If services necessary as a result of a dental accident are not covered under your medical coverage, Delta Dental will pay up to 100% of the Contract Dentist’s “filed fees,” for expenses an Enrollee incurs for an accidental injury, less any applicable Copayments.

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.

"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.
If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Non-Discrimination

Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Company:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Customer Service Center at 800-471-9925.

If you believe that Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

DeltaCare USA
18000 Studebaker Road, Ste. 530
Cerritos, CA 90703
Telephone Number: 800-471-9925
Website Address: https://www1.deltadentalins.com/group-sites/uc.html

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)