A Prepaid Dental Plan for

UNIVERSITY OF CALIFORNIA
Employees, Retirees, and Their Dependents

Evidence of Coverage and Disclosure Statement
January 1, 2008

Provided by:

Delta Dental of California (formerly PMI)
12898 Towne Center Drive
Cerritos, CA 90703-8579
800-422-4234
www.deltadentalins.com/uc
This booklet is a Summary of the Dental Program ("Program") and has been prepared for participants who are Employees and Retirees of the University of California.

This Program has been established and is maintained and administered in accordance with the provisions of Group Dental Contract Number AG109.UC issued by:

Delta Dental of California (formerly PMI)
12898 Towne Center Drive
Cerritos, CA 90703-8579
800-422-4234
562-924-8311

web site: www.deltadentalins.com/uc

IMPORTANT
This booklet is subject to the provisions of the Group Dental Service Contract and The University of California Group Insurance Regulations and cannot modify or affect the provisions of these documents in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. Some provisions of this Program may not apply to Employees in certain exclusively represented bargaining units.
This booklet is a Combined Evidence of Coverage and Disclosure Form (“EOC”) for your DeltaCare USA Dental HMO Program (“Program”) provided by Delta Dental of California (“Delta Dental”). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract (“Contract”) issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

PLEASE READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED “SPECIAL NEEDS”.

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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The telephone number at which you may obtain information about benefits is 800-422-4234.
# Table Of Contents

University of California Eligibility, Enrollment and Plan Administration Provisions - January 1, 2008 .......................... 1

Eligibility .................................................................................................................. 1

Enrollment .................................................................................................................. 4

Termination of Coverage .......................................................................................... 6

Plan Administration ................................................................................................. 7

Definitions ................................................................................................................. 9

General Information ................................................................................................. 11

How to use the DeltaCare USA Program - Choice of Contract Dentist ............. 11

Continuity of Care ..................................................................................................... 12

Special Needs ............................................................................................................ 12

Facility Accessibility ................................................................................................. 13

Benefits, Limitations and Exclusions ...................................................................... 13

Copayments and Other Charges .............................................................................. 13

Emergency Services ................................................................................................. 13

International Dentist Referral Service ................................................................. 13

Specialist Services .................................................................................................. 14

Second Opinion ....................................................................................................... 14

Claims for Reimbursement ...................................................................................... 15

Provider Compensation ........................................................................................... 15

Processing Policies .................................................................................................. 15
Coordination of Benefits .......................................................... 15
Enrollee Complaint Procedure ............................................... 16
Standing Committee on Public Policy ..................................... 17
Termination of Benefits ......................................................... 18
Organ and Tissue Donation ..................................................... 18
Description of Benefits and Copayments ............................... 19
Limitations of Benefits .......................................................... 31
Exclusions of Benefits ........................................................... 34
Temporomandibular Joint Benefit ......................................... 36
Dental Implants ................................................................... 37
Dental Accident Benefits ....................................................... 37
University of California Eligibility, Enrollment and Plan Administration Provisions - January 1, 2008

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own health and welfare plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"). Portions of these Regulations are summarized below.

Eligibility

The following individuals are eligible to enroll in this Plan. They are only eligible to enroll in the plan if they meet the Plan's geographic service criteria as residents of California.

Subscriber Employee

You are eligible if you have an appointment type which is eligible for benefits, and are a member of a UC-sponsored retirement plan. Generally, there are two ways to qualify for UCRP membership: 1) you are appointed to work at least 50% time for a year or more or 2) you worked 1,000* hours in a rolling twelve-month period in a position eligible for UCRP membership. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment.

* Lecturers - see your Benefits Office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree

A former University Employee receiving monthly benefits from a University sponsored defined benefit plan. For UC health & welfare purposes, a Retiree must also satisfy graduated eligibility rules, if applicable, and meet other requirements set forth in the University of California Group Insurance Regulations.

You may continue University dental plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

a) you meet the University's service credit requirements for Retiree dental eligibility including graduated eligibility, if applicable;

b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor Retiree); and

c) you elect to continue dental coverage at the time of retirement.
For more information about continuing dental plan coverage into retirement, including service credit and graduated eligibility requirements, see the UC Retirement Handbook or contact the University's Customer Service Center.

A **Survivor** - a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan - may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members.

**Eligible Dependents (Family Members)**

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the specific Participation Terms and Conditions outlined on the form and the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

**Spouse:** Your legal spouse.

**Child:** All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors.

The following categories are eligible:

a) your natural or legally adopted children;
b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse’s dependents for income tax purposes;
c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse’s dependents for income tax purposes;
d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

a) the incapacity began before age 23, the child was enrolled in a group dental plan before age 23 and coverage is continuous;
b) the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and

c) the child lives with you if he or she is not your or your spouse’s natural or adopted child.
Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored health plan are eligible for continued coverage under any other University-sponsored dental plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group dental coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

**Other Eligible Dependents (Family Members)**
You may enroll a same sex domestic partner (and the same sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations.

The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and the domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

**Additional Requirements**
If you enroll your eligible domestic partner and/or your partner's eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, the UC/employer contribution for their dental coverage may be considered your taxable income, subject to FICA (Social Security and Medicare) and federal and California state income tax withholding.

**No Dual Coverage**
Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor Retiree or an Eligible Dependent, but not under any combination of these. If an Enrollee and the Enrollee's spouse or same-sex/opposite-sex Domestic Partner are both eligible Subscribers, each may enroll separately or one may cover the other as an Eligible Dependent. If they enroll separately, neither may enroll the other as an Eligible Dependent. Eligible children may be enrolled under either parent's or Domestic Partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored dental plans.

**More Information**
For more information on who qualifies for dental coverage, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: atyourservice@ucop.edu.
Enrollment
For information about enrolling yourself or an Eligible Dependent, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)
A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any Eligible Dependents during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly Eligible Dependent during his or her PIE. The Eligible Dependent's PIE starts the day your Eligible Dependent becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other Eligible Dependent if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any Eligible Dependent. Eligible Dependents are only eligible for the same plan you are enrolled in.

a) For a spouse, on the date of marriage. Survivor Retirees may not add Spouses to their coverage.
b) For a natural child, on the child's date of birth.
c) For an adopted child, the earlier of: (i) the date you or your Spouse has the legal right to control the child's health care, or (ii) the date the child is placed in your physical custody.
   If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your Eligible Dependents because of other group dental plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your family members), you may be able to enroll yourself and those Eligible Dependents during a PIE that starts on the day the other coverage is no longer in effect.
If you are enrolled in the DeltaCare USA Program and you move or are transferred out of the DeltaCare USA service area (California), or will be away from the DeltaCare USA service area for more than two months, you will have a PIE to enroll yourself and your Eligible Dependents in another University dental plan. Your PIE starts with the effective date of the move or the date you leave the DeltaCare USA service area.

**At Other Times**
You and your Eligible Dependents may also enroll during a group open enrollment period established by the University.

If you have two or more Eligible Dependents enrolled in the Plan, you may add a newly Eligible Dependent at any time. See "Effective Date."

If you are a Retiree, you may continue coverage for yourself and your enrolled Eligible Dependents in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Eligible Dependents before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor Retiree, you may not enroll your legal spouse or Domestic Partner.

If you are a Qualified COBRA continuant, you may add Eligible Dependents during the open enrollment period.

**Effective Date**
The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Eligible Dependents is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Eligible Dependents is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

a) the date the child becomes eligible, or

b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.
Change in Coverage
In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Termination of Coverage
The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status
If you are an Employee and lose eligibility, your coverage and that of any enrolled Eligible Dependent stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor Retiree and your annuity terminates, your coverage and that of any enrolled Eligible Dependent stops at the end of the last month in which you are eligible for an annuity.

If your Eligible Dependent loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Eligible Dependent is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Misuse
Coverage for you or your Family Members may be terminated for misuse of the Plan, including but not limited to such actions as fraud or deception in the use of the services of the Plan, knowingly permitting such fraud or deception by another, or threats or abusive behavior towards Plan providers or representatives. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who misuses the Plan will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber misuses the Plan, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement
Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage
If your coverage or that of an Eligible Dependent ends, you and/or your Eligible Dependent may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice 'Continuation of Group Insurance Coverage', available from the UC At Your Service website
Plan Administration
By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the group insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits - particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan
The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612-3557
800-888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Delta Dental at the following address and phone number:
Delta Dental of California
12898 Towne Center Drive
Cerritos, California 90703-8579
800-422-4234
562-924-8311

Group Contract Number
The Group Contract Number for this Plan is: AG109.UC
Type of Plan
This Plan is a health and welfare plan that provides group dental care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plan
The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The plan is not a vested plan. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, and what portion of the premiums you and the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements
The benefits under the Plan are provided by Delta Dental under a Group Dental Service Contract. The cost of the premiums is currently paid entirely by the University of California.

Agent for Serving of Legal Process
Legal process may be served on Delta Dental, at the address listed above.

Your Rights under the Plan
As a participant in a University of California dental plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:
- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the insurance contract, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.
Definitions
As used in this booklet:

Additional Fee(s) - shall mean the difference in cost of the covered benefit and the Usual Fee for Optional treatment.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and 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 who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services, and who 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 of an Eligible Employee or Eligible Retiree who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Eligible Retiree means any Retiree who is eligible for Benefits as described in this booklet.

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i) placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Enrollee means an Eligible Employee/Eligible Retiree ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Medically Necessary General Anesthesia - shall mean 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.
**Member** - shall mean a person who is actually enrolled in the "DeltaCare USA Program." The term "Member" or "Members" used herein shall also include all Eligible Employees, Retirees/Survivor Retirees and Dependents of the Employee, (as defined in the Eligibility Section), who are enrolled for coverage under this plan.

**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 Benefit under the Enrollee's plan.

**Reasonable** means that an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist.

**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.

**Usual Fee** means the fee that an individual Dentist most frequently charges for a given dental service.

**We, Us or Our** means Delta Dental of California.
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.

Premiums
The Client will be responsible for sending all payments of premiums to us.

How to use the DeltaCare USA Program - 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. 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 at least five (5) working days prior to 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.

When you arrive at your Contract Dentist's office for your appointment, present your membership card. You will receive all necessary reasonable and customary care as listed in the Description of Benefits on pages 19 through 28. Work will be done according to a Treatment Plan carefully developed by your Contract Dentist.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED 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 do not hesitate to 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 (a) a partial or full denture for which final impressions have been taken, and (b) 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 Enrollees:

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 Enrollees:

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 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 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. This policy does not apply to new Enrollees of an individual subscriber contract.

**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 either 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 Services
If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee and do not have an assigned Contract Dentist yet, and you need Emergency Services, you should contact Delta Dental's Customer Service department at 800-422-4234 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:
1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is reasonable for you to access Emergency Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

Benefits for Emergency Services not provided by the Contract Dentist are limited to a maximum of $100.00 per emergency less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Contract Dentist.

International Dentist Referral Service
Care outside the United States
You can receive your covered out-of-network emergency dental care when you are outside of the United States through a partnership between Delta Dental and International SOS Assistance, Inc. (I-SOS). I-SOS provides referrals to 3,200 dentist
or dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help you find a dentist. For more information, check our web site at www.deltadentalins.com/uc or call 800-523-6586 from the U.S. Once you leave the U.S., you can call I-SOS at 215-942-8226 - collect.

When you see an I-SOS dentist, you must pay for your treatment at the time of service and get a detailed receipt from the dentist. In addition to providing the dentist's name and address (including country), this receipt should describe the services performed by the dentist and indicate the tooth or teeth that were treated. It should also indicate whether the dentist's charges were billed in U.S. dollars or another currency.

Once we receive your claim, we will reimburse you subject to the terms and conditions of your DeltaCare USA coverage. Reimbursement is based on the out-of-network emergency benefit provided through your group plan, noted above. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

**Specialist Services**

Specialist and Orthodontic Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and *Limitations and Exclusions* to determine which procedures are covered under this Program.

**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 of imminent and serious health threat 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 pages 16-17 for information on Enrollee Complaint Procedures.

**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 Delta Dental, 12898 Towne Center Drive, Cerritos, CA 90703.

**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 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.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall 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 Benefits 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 Delta Dental's Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

```
Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, CA 90703-8579
```

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 must file a request for review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our 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, we 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 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an 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. We will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat 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 in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

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, 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 an 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 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.

IMR has limited application to your dental program. You may request an IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

**Standing Committee on Public Policy**

A six member committee, comprised of one Dentist, four representatives from the purchaser and subscriber community and one member of the Delta Dental Board of
Directors, meets quarterly and participates in establishing policies to assure the comfort, dignity, and convenience of Enrollees and the public. Issues may be presented to this committee by writing to Delta Dental's Public Policy Committee, c/o Professional Relations, at the address on the back of this booklet.

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 cancelled or not renewed because of your health status or requirements for health care services, or that of your dependent(s), you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to Enrollee Complaint Procedure on pages 16-17.

Organ and Tissue Donation
Donating organs and tissue 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.
SCHEDULE A
Description of Benefits and Copayments

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

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

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>ENROLLEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100-D0999</td>
<td>I. DIAGNOSTIC</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>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral <em>radiographs</em> - complete series (including bitewings) - limited to 1 series every 12 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - first film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0260</td>
<td>Extraoral - each additional film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing <em>radiograph</em> - single film</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings <em>radiographs</em> - two films</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings <em>radiographs</em> - three films</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings <em>radiographs</em> - four films - limited to 1 series every 6 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 films</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>No Cost</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Cost</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>D0415</td>
<td>Collection of microorganisms for culture and sensitivity</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>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0999</td>
<td>Unspecified diagnostic procedure, by report - <em>includes office visit, per visit (in addition to other services)</em></td>
<td>No Cost</td>
</tr>
</tbody>
</table>

**D1000-D1999  II. PREVENTIVE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis cleaning - adult - 2 per 12 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1110</td>
<td><em>Additional prophylaxis cleaning - adult (within the 12 month period)</em></td>
<td>$45.00</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis cleaning - child - 2 per 12 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1120</td>
<td><em>Additional prophylaxis cleaning - child (within the 12 month period)</em></td>
<td>$35.00</td>
</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (prophylaxis not included) - child to age 19; 2 per 12 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - <em>child to age 19; 2 per 12 month period</em></td>
<td>No Cost</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for control of dental disease</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant - per tooth - <em>limited to permanent molars through age 15</em></td>
<td>No Cost</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer - removable - unilateral</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cementation of space maintainer</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
<td>No Cost</td>
</tr>
</tbody>
</table>

**D2000-D2999  III. RESTORATIVE**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>No Cost</td>
</tr>
</tbody>
</table>

- 20 -  CAM95 EOC - V7
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite - one surface, posterior</td>
<td>$65.00</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior</td>
<td>$75.00</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior</td>
<td>$85.00</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior</td>
<td>$95.00</td>
</tr>
<tr>
<td>D2510</td>
<td>Inlay - metallic - one surface</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2520</td>
<td>Inlay - metallic - two surfaces</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2530</td>
<td>Inlay - metallic - three or more surfaces</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2542</td>
<td>Onlay - metallic - two surfaces</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay - metallic - three surfaces</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay - metallic - four or more surfaces</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2610</td>
<td>Inlay - porcelain/ceramic - one surface</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2620</td>
<td>Inlay - porcelain/ceramic - two surfaces</td>
<td>$250.00</td>
</tr>
<tr>
<td>D2630</td>
<td>Inlay - porcelain/ceramic - three or more surfaces</td>
<td>$300.00</td>
</tr>
<tr>
<td>D2642</td>
<td>Onlay - porcelain/ceramic - two surfaces</td>
<td>$270.00</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic - three surfaces</td>
<td>$340.00</td>
</tr>
<tr>
<td>D2644</td>
<td>Onlay - porcelain/ceramic - four or more surfaces</td>
<td>$370.00</td>
</tr>
<tr>
<td>D2650</td>
<td>Inlay - resin-based composite - one surface</td>
<td>$100.00</td>
</tr>
<tr>
<td>D2651</td>
<td>Inlay - resin-based composite - two surfaces</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2652</td>
<td>Inlay - resin-based composite - three or more surfaces</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2662</td>
<td>Onlay - resin-based composite - two surfaces</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2663</td>
<td>Onlay - resin-based composite - three surfaces</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2664</td>
<td>Onlay - resin-based composite - four or more surfaces</td>
<td>$250.00</td>
</tr>
<tr>
<td>D2710</td>
<td>Crown - resin-based composite (indirect)</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2712</td>
<td>Crown - ¾ resin-based composite (indirect)</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2720</td>
<td>Crown - resin with high noble metal</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2721</td>
<td>Crown - resin with predominantly base metal</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2722</td>
<td>Crown - resin with noble metal</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - ¾ cast high noble metal</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown - ¾ cast predominantly base metal</td>
<td>$50.00</td>
</tr>
</tbody>
</table>
D2782  Crown - \( \frac{3}{4} \) cast noble metal \(^2\) ...................................................... $50.00
D2783  Crown - \( \frac{3}{4} \) porcelain/ceramic \(^2\) ...................................................... $50.00
D2790  Crown - full cast high noble metal \(^2\) ...................................................... $150.00
D2791  Crown - full cast predominantly base metal \(^2\) ........................................ $50.00
D2792  Crown - full cast noble metal \(^2\) ...................................................... $50.00
D2794  Crown - titanium \(^2\) ................................................................. No Cost
D2910  Recement inlay, onlay or partial coverage restoration............................ No Cost
D2915  Recement cast or prefabricated post and core ........................................ No Cost
D2920  Recement crown .................................................................................. No Cost
D2930  Prefabricated stainless steel crown - primary tooth .............................. 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  Sedative filling ..................................................................................... No Cost
D2950  Core buildup, including any pins .......................................................... 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 \(^1\) ........................................................................................................................................ No Cost
D2953  Each additional indirectly fabricated post - same tooth - includes canal preparation \(^1\) .......................................................... No Cost
D2954  Prefabricated post and core in addition to crown - base metal post; includes canal preparation ............................................. No Cost
D2957  Each additional prefabricated post - same tooth - base metal post; includes canal preparation ........................................ No Cost
D2970  Temporary crown (fractured tooth) - palliative treatment only .......... No Cost
D2971  Additional procedures to construct new crown under existing partial denture framework .............................................. $10.00
D2980  Crown repair, by report .......................................................................... 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
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 - anterior (excluding final restoration) ............................ $20.00
D3320  Root canal - bicuspid (excluding final restoration) ............................. $40.00
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3330</td>
<td>Root canal - molar (excluding final restoration)</td>
<td>$60.00</td>
</tr>
<tr>
<td>D3331</td>
<td>Treatment of root canal obstruction; non-surgical access</td>
<td>$45.00</td>
</tr>
<tr>
<td>D3332</td>
<td>Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
<td>$45.00</td>
</tr>
<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects</td>
<td>$45.00</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior</td>
<td>$20.00</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - bicuspid</td>
<td>$40.00</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar</td>
<td>$60.00</td>
</tr>
<tr>
<td>D3351</td>
<td>Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>$70.00</td>
</tr>
<tr>
<td>D3352</td>
<td>Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>$45.00</td>
</tr>
<tr>
<td>D3353</td>
<td>Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)</td>
<td>$45.00</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery - bicuspid (first root)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery - molar (first root)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling - per root</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation, per root - not covered in conjunction with a hemisection</td>
<td>No Cost</td>
</tr>
</tbody>
</table>

**V. PERIODONTICS**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$100.00</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$100.00</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue graft procedure</td>
<td>$150.00</td>
</tr>
<tr>
<td>D4271</td>
<td>Free soft tissue graft procedure (including donor site surgery)</td>
<td>$150.00</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing - four or more teeth per quadrant - limited to 5 quadrants during any 12 consecutive months</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
D4342  Periodontal scaling and root planing - one to three teeth per quadrant - limited to 5 quadrants during any 12 consecutive months  ..............................................................  No Cost

D4355  Full mouth debridement to enable comprehensive evaluation and diagnosis - 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

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 any conventional clasps, rests and teeth) 5,6 .................................................................  $65.00

D5212  Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) 5,6 .................................................................  $65.00

D5213  Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) 5,6 .................................................................  $65.00

D5214  Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) 5,6 .................................................................  $65.00

D5225  Maxillary partial denture - flexible base (including any clasps, rests and teeth) 5,6 .................................................................  $115.00

D5226  Mandibular partial denture - flexible base (including any clasps, rests and teeth) 5,6 .................................................................  $115.00

D5410  Adjust complete denture - maxillary ...............................................................  No Cost

D5411  Adjust complete denture - mandibular ............................................................  No Cost

D5421  Adjust partial denture - maxillary .................................................................  No Cost

D5422  Adjust partial denture - mandibular .................................................................  No Cost

D5510  Repair broken complete denture base ..............................................................  No Cost

D5520  Replace missing or broken teeth - complete denture (each tooth) .................................................................  No Cost

D5610  Repair resin denture base ...........................................................................  No Cost

D5620  Repair cast framework ............................................................................  No Cost

D5630  Repair or replace broken clasp .....................................................................  No Cost

D5640  Replace broken teeth - per tooth ....................................................................  No Cost

D5650  Add tooth to existing partial denture ....................................................................  No Cost

D5660  Add clasp to existing partial denture ....................................................................  No Cost
D5710  Rebase complete maxillary denture 7  ........................................... $20.00  
D5711  Rebase complete mandibular denture 7  ........................................... $20.00  
D5720  Rebase maxillary partial denture 7  ........................................... $20.00  
D5721  Rebase mandibular partial denture 7  ........................................... $20.00  
D5730  Reline complete maxillary denture (chairside) 7  ........................................... No Cost  
D5731  Reline complete mandibular denture (chairside) 7  ........................................... No Cost  
D5740  Reline maxillary partial denture (chairside) 7  ........................................... No Cost  
D5741  Reline mandibular partial denture (chairside) 7  ........................................... No Cost  
D5750  Reline complete maxillary denture (laboratory) 7  ........................................... No Cost  
D5751  Reline complete mandibular denture (laboratory) 7  ........................................... No Cost  
D5760  Reline maxillary partial denture (laboratory) 7  ........................................... No Cost  
D5761  Reline mandibular partial denture (laboratory) 7  ........................................... No Cost  
D5820  Interim partial denture (maxillary) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing 5  ........................................... No Cost  
D5821  Interim partial denture (mandibular) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing 5  ........................................... No Cost  
D5850  Tissue conditioning, maxillary 3,7  ........................................... No Cost  
D5851  Tissue conditioning, mandibular 3,7  ........................................... No Cost  

D5900-D5999  VII. MAXILLOFACIAL PROSTHESES - Not Covered  

D6000-D6199  VIII. IMPLANT SERVICES - Optional  
Option implant services - Subject to Limitation #12 8  .......... Optional  

D6200-D6999  IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])  
D6210  Pontic - cast high noble metal 7  ........................................... $150.00  
D6211  Pontic - cast predominantly base metal 9  ........................................... $50.00  
D6212  Pontic - cast noble metal 7  ........................................... $50.00  
D6240  Pontic - porcelain fused to high noble metal 8,9  ........................................... $150.00  
D6241  Pontic - porcelain fused to predominantly base metal 8,9  ........................................... $50.00  
D6242  Pontic - porcelain fused to noble metal 8,9  ........................................... $50.00  
D6245  Pontic - porcelain/ceramic 8,9  ........................................... $50.00  
D6250  Pontic - resin with high noble metal 8,9  ........................................... $150.00  
D6251  Pontic - resin with predominantly base metal 8,9  ........................................... $50.00  
D6252  Pontic - resin with noble metal 8,9  ........................................... $50.00  
D6600  Inlay - porcelain/ceramic, two surfaces 9  ........................................... $250.00  
D6601  Inlay - porcelain/ceramic, three or more surfaces 9  ........................................... $300.00  
D6602  Inlay - cast high noble metal, two surfaces 9  ........................................... $100.00  
D6603  Inlay - cast high noble metal, three or more surfaces 9  ........................................... $100.00
D6604  Inlay - cast predominantly base metal, two surfaces ⁹ .......... No Cost
D6605  Inlay - cast predominantly base metal, three or more surfaces ⁹ ................................. No Cost
D6606  Inlay - cast noble metal, two surfaces ⁹ .............................................. No Cost
D6607  Inlay - cast noble metal, three or more surfaces ⁹ .............................................. No Cost
D6608  Onlay - porcelain/ceramic, two surfaces ⁹ .............................................. $270.00
D6609  Onlay - porcelain/ceramic, three or more surfaces ⁹ .............................................. $370.00
D6610  Onlay - cast high noble metal, two surfaces ⁹ .............................................. $100.00
D6611  Onlay - cast high noble metal, three or more surfaces ⁹ .............................................. $100.00
D6612  Onlay - cast predominantly base metal, two surfaces ⁹ .............................................. No Cost
D6613  Onlay - cast predominantly base metal, three or more surfaces ⁹ ................................. No Cost
D6614  Onlay - cast noble metal, two surfaces ⁹ .............................................. No Cost
D6615  Onlay - cast noble metal, three or more surfaces ⁹ .............................................. No Cost
D6720  Crown - resin with high noble metal 3,9 ................................................ $150.00
D6721  Crown - resin with predominantly base metal 3,9 ................................................ $50.00
D6722  Crown - resin with noble metal 3,9 ................................................ $50.00
D6740  Crown - porcelain/ceramic 3,9 ................................................ $50.00
D6750  Crown - porcelain fused to high noble metal 3,9 ................................................ $150.00
D6751  Crown - porcelain fused to predominantly base metal 3,9 ................................................ $50.00
D6752  Crown - porcelain fused to noble metal 3,9 ................................................ $50.00
D6780  Crown - ¾ cast high noble metal ⁹ ................................................ $150.00
D6781  Crown - ¾ cast predominantly base metal ⁹ ................................................ $50.00
D6782  Crown - ¾ cast noble metal ⁹ ................................................ $50.00
D6783  Crown - ¾ porcelain/ceramic ⁹ ................................................ $50.00
D6790  Crown - full cast high noble metal ⁹ ................................................ $150.00
D6791  Crown - full cast predominantly base metal ⁹ ................................................ $50.00
D6792  Crown - full cast noble metal ⁹ ................................................ $50.00
D6930  Recement fixed partial denture .............................................................. No Cost
D6940  Stress breaker ⁹ .............................................................. No Cost
D6970  Post and core in addition to fixed partial denture retainer, indirectly fabricated - includes canal preparation ¹ ................................................ No Cost
D6971  Prefabricated post and core in addition to fixed partial denture retainer - base metal post; includes canal preparation ................................................ No Cost
D6973  Core buildup for retainer, including any pins ................................................ No Cost
D6976  Each additional indirectly fabricated post - same tooth - includes canal preparation ¹ ................................................ No Cost
D6977  Each additional prefabricated post - same tooth - base metal post; includes canal preparation ................................................ No Cost
D6980  Fixed partial denture repair, by report ................................................ No Cost
**D7000-D7999  X. ORAL AND MAXILLOFACIAL SURGERY**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>$15.00</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>$15.00</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>$15.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>$15.00</td>
</tr>
<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots (cutting procedure)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
<td>$85.00</td>
</tr>
<tr>
<td>D7282</td>
<td>Mobilization of erupted or malpositioned tooth to aid eruption</td>
<td>$85.00</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of oral tissue - soft - <em>does not include pathology</em> *does not include pathology laboratory procedures*</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloectomy in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloectomy in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloectomy not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloectomy not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7410</td>
<td>Excision of benign lesion up to 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7411</td>
<td>Excision of benign lesion greater than 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7460</td>
<td>Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7461</td>
<td>Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible) - <em>per site</em></td>
<td>No Cost</td>
</tr>
<tr>
<td>D7472</td>
<td>Removal of torus palatinus</td>
<td>No Cost</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal of torus mandibularis</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
Incision and drainage of abscess - intraoral soft tissue ................. No Cost
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
Frenulectomy (frenectomy or frenotomy) - separate procedure .... No Cost
Excision of hyperplastic tissue - per arch ........................................ $50.00
Excision of pericoronar gingiva ...................................................... $50.00

XI. ORTHODONTICS
Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 $1,000.00
Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 $1,000.00
Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children $1,000.00
Pre-orthodontic treatment visit - not to be charged with any other consultation procedure(s) No Cost
Orthodontic retention (removal of appliances, construction and placement of retainers) No Cost
Unspecified orthodontic procedure, by report - includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding No Cost

XII. ADJUNCTIVE GENERAL SERVICES
Palliative (emergency) treatment of dental pain - minor procedure No Cost
Regional block anesthesia ......................................................... No Cost
Trigeminal division block anesthesia .......................................... No Cost
Local anesthesia ...................................................................... No Cost
Deep sedation/general anesthesia - first 30 minutes - limitations apply. Refer to Schedule B, Limitation #10 ........................................ No Cost
Deep sedation/general anesthesia - each additional 15 minutes - limitations apply. Refer to Schedule B, Limitation #10 ............... No Cost
Intravenous conscious sedation/analgesia - first 30 minutes - limitations apply. Refer to Schedule B, Limitation #10 ......................... No Cost
Intravenous conscious sedation/analgesia - each additional 15 minutes - limitations apply. Refer to Schedule B, Limitation #10 No Cost
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician No Cost
Office visit for observation (during regularly scheduled hours) - no other services performed ......................................................... No Cost
Office visit - after regularly scheduled hours ................................ $20.00
Case presentation, detailed and extensive treatment planning No Cost
Occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction .......... No Cost

Occlusal adjustment, limited - a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction .......... No Cost

Occlusal adjustment, complete - a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction .......... No Cost

External bleaching - per arch - limited to one bleaching tray and gel for two weeks of self treatment ................................................................. $125.00

Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00 ............... $10.00

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

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

FOOTNOTES

1. 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.

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

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

4. A benefit for permanent teeth only.

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

8. 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.

9 Replacement is subject to a limitation requiring the existing bridge to be 3+ years old.

10 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.

11 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.

12 Includes adjustments and/or office visits up to 36 months. After 36 months, a monthly fee of $75.00 applies.
SCHEDULE B
Limitations of Benefits

Limitations
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/intravenous conscious sedation and the services of a special anesthesiologist, except upon preauthorization by Delta Dental for covered services only and receipt of a written authorization from the enrollee's physician for:
    - enrollees who have a disability (such as Down's Syndrome, Autism, Asperger's Syndrome, etc.) that necessitates the use of anesthesia to provide treatment.
    - medically necessary extractions.

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**

**Exclusions**

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 D9972, External bleaching, 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 the assigned 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 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.

21. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

22. Extractions solely for the purpose of orthodontics.

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

24. Transfer after banding has been initiated.
**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)
- D9940 Occlusal guard, by report
- 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.
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 Implants**

While dental implant procedures are not a benefit under your program, the DeltaCare USA program allows for an optional benefit toward prosthetic appliances placed on implants. Please review limitation #12 in this booklet. Clarify the charges with your assigned network dentist prior to starting treatment. Not all network dentists provide this service, and this optional benefit is not available out-of-network.

**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

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