



Keep Smiling

DeltaCare[®] USA

provided by

Delta Dental of California

Basic Benefits - Plan CAM34

Dental benefits made easy!

When you enroll in a DeltaCare USA¹ plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.²

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums³ for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

- 2034-0001 Basic
- 2034-0002 Basic Direct Pay
- 2034-0003 Basic Cobra
- 2034-0004 Basic Retiree

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

¹ DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, MI, MN, NE, OR, RI, SC, WA, WI — Dentegra Insurance Company; DC, DE, FL, GA, KS, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

² We recommend that you verify online that the dentist is your selected DeltaCare USA primary care dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.



We keep you smiling[®]
deltadentalins.com/csu

FAQ + A

Answers to frequently asked questions about your DeltaCare USA plan

GETTING STARTED

1. How do I enroll in a DeltaCare USA plan?

Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. How do I get started using my DeltaCare USA plan?

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

- **The name, address and phone number of your selected primary care dentist:** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
- **Your Evidence/Certificate of Coverage (plan booklet):** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
- **An ID card:** This card is for your records only — you do not need to present it in order to receive treatment.

3. How long will it take to get an appointment with my primary care dentist?

Two to four weeks¹ is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. How much will my dental treatments cost? How do I pay?

With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

CHOOSING A DENTIST

5. How do I select my primary care dentist?

When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at deltadentalins.com and select the DeltaCare USA network. If you do not select a dentist when you enroll, we will choose one for you.

6. Does everyone in my family have to choose the same primary care dentist?

No. Each family member can select his or her own primary care network dentist.

7. Can I change my primary care dentist?

Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or call or write to Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

¹ In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.

8. My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?

No. You must visit your selected primary care network dentist to receive benefits under this plan. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists.

9. What should I do if I need to see a specialist?

If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

GENERAL PLAN INFORMATION

10. If I'm traveling, is emergency treatment covered under my plan?

You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles² from your primary care dentist. Your out-of-area emergency benefit (typically limited to \$100 per person³) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

11. Can I access my plan online?

Yes. Visit deltadentalins.com/csu to create a free, secure online account. On our website, you can access your plan benefits and ID card, select (or change) your primary care dentist — and more.

12. Does my plan cover pre-existing conditions? What about treatments that are in progress?

Treatment for pre-existing conditions (except work in progress³), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

13. Does my plan cover teeth whitening?

No. Whitening is not a covered benefit under your plan.

14. Does my plan cover tooth-colored fillings and crowns?

Yes. Porcelain and other tooth-colored materials are included in this plan.

15. What if I have additional questions about my plan?

Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

² In TX, there is no limit on the number of miles or on the dollar amount per emergency.

³ In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

We make it easy for you!



Select a
DeltaCare USA
dentist



Receive your
welcome materials



Schedule an
appointment



Receive
dental care



Pay only your
share to dentist

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 and governing administrative policies of the program. Please refer to *Schedules B, C and F* 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 Current Dental Terminology ("CDT"), CDT-2018 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 3 years</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 3 years</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 3 years</i>	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis <i>cleaning</i> - adult - <i>2 D1110, D1120 or D4346 per calendar year</i>	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - <i>2 D1110, D1120 or D4346 per calendar year</i>	No Cost
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars to age 14</i>	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars to age 14</i>	\$5.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars to age 14</i>	\$5.00
D1354	Interim caries arresting medicament application - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost

D1510	Space maintainer - fixed - unilateral	\$10.00
D1515	Space maintainer - fixed - bilateral	\$10.00
D1520	Space maintainer - removable - unilateral	\$10.00
D1525	Space maintainer - removable - bilateral	\$10.00
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - <i>child to age 9</i>	\$10.00

D2000-D2999**III. RESTORATIVE**

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2510	Inlay - metallic - one surface ⁴	\$50.00
D2520	Inlay - metallic - two surfaces ⁴	\$50.00
D2530	Inlay - metallic - three or more surfaces ⁴	\$50.00
D2543	Onlay - metallic - three surfaces ⁴	\$50.00
D2544	Onlay - metallic - four or more surfaces ⁴	\$50.00
D2710	Crown - resin-based composite (indirect)	\$35.00
D2712	Crown - 3/4 resin-based composite (indirect)	\$35.00
D2720	Crown - resin with high noble metal ^{2, 4}	\$50.00
D2721	Crown - resin with predominantly base metal ²	\$50.00
D2722	Crown - resin with noble metal ²	\$50.00
D2740	Crown - porcelain/ceramic ²	\$50.00
D2750	Crown - porcelain fused to high noble metal ^{2, 4}	\$50.00
D2751	Crown - porcelain fused to predominantly base metal ²	\$50.00
D2752	Crown - porcelain fused to noble metal ²	\$50.00
D2780	Crown - 3/4 cast high noble metal ⁴	\$50.00
D2781	Crown - 3/4 cast predominantly base metal	\$50.00
D2782	Crown - 3/4 cast noble metal	\$50.00
D2790	Crown - full cast high noble metal ⁴	\$50.00
D2791	Crown - full cast predominantly base metal	\$50.00
D2792	Crown - full cast noble metal	\$50.00
D2794	Crown - titanium ⁴	\$50.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ⁴	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ⁴	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars to age 14</i>	\$5.00

D3000-D3999**IV. ENDODONTICS**

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinoceamental junction and application of medicament	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$20.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$40.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration)	\$60.00
D3346	Retreatment of previous root canal therapy - anterior	\$20.00
D3347	Retreatment of previous root canal therapy - premolar	\$40.00
D3348	Retreatment of previous root canal therapy - molar	\$60.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (<i>to age 14</i>)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) (<i>to age 14</i>)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) (<i>to age 14</i>)	No Cost
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i>	No Cost

D4000-D4999**V. PERIODONTICS**

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$20.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$10.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$10.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>2 D1110, D1120 or D4346 per calendar year</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$10.00
D4910	Periodontal maintenance - <i>limited to 2 treatments each 12 month period</i>	\$8.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899**VI. PROSTHODONTICS (removable)**

D5110	Complete denture - maxillary	\$60.00
D5120	Complete denture - mandibular	\$60.00
D5130	Immediate denture - maxillary	\$60.00
D5140	Immediate denture - mandibular	\$60.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$70.00

D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$70.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$70.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$70.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$70.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$70.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$70.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$70.00
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
D5511	Repair broken complete denture base, mandibular	\$15.00
D5512	Repair broken complete denture base, maxillary	\$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$15.00
D5611	Repair resin partial denture base, mandibular	\$15.00
D5612	Repair resin partial denture base, maxillary	\$15.00
D5621	Repair cast partial framework, mandibular	\$15.00
D5622	Repair cast partial framework, maxillary	\$15.00
D5630	Repair or replace broken clasp - per tooth	\$15.00
D5640	Replace broken teeth - per tooth	\$15.00
D5650	Add tooth to existing partial denture	\$5.00
D5660	Add clasp to existing partial denture - per tooth	\$5.00
D5710	Rebase complete maxillary denture	\$15.00
D5711	Rebase complete mandibular denture	\$15.00
D5720	Rebase maxillary partial denture	\$15.00
D5721	Rebase mandibular partial denture	\$15.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	\$15.00
D5751	Reline complete mandibular denture (laboratory)	\$15.00
D5760	Reline maxillary partial denture (laboratory)	\$15.00
D5761	Reline mandibular partial denture (laboratory)	\$15.00
D5820	Interim partial denture (maxillary) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing</i>	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered****D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

D6210	Pontic - cast high noble metal ⁴	\$50.00
D6211	Pontic - cast predominantly base metal	\$50.00
D6212	Pontic - cast noble metal	\$50.00
D6240	Pontic - porcelain fused to high noble metal ^{2,4}	\$50.00
D6241	Pontic - porcelain fused to predominantly base metal ²	\$50.00
D6242	Pontic - porcelain fused to noble metal ²	\$50.00

D6250	Pontic - resin with high noble metal ^{2,4}	\$50.00
D6251	Pontic - resin with predominantly base metal ²	\$50.00
D6252	Pontic - resin with noble metal ²	\$50.00
D6602	Retainer inlay - cast high noble metal, two surfaces ⁴	\$50.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces ⁴	\$50.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$50.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$50.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$50.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$50.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces ⁴	\$50.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$50.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$50.00
D6720	Retainer crown - resin with high noble metal ^{2,4}	\$50.00
D6721	Retainer crown - resin with predominantly base metal ²	\$50.00
D6722	Retainer crown - resin with noble metal ²	\$50.00
D6750	Retainer crown - porcelain fused to high noble metal ^{2,4}	\$50.00
D6751	Retainer crown - porcelain fused to predominantly base metal ²	\$50.00
D6752	Retainer crown - porcelain fused to noble metal ²	\$50.00
D6780	Retainer crown - 3/4 cast high noble metal ⁴	\$50.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$50.00
D6782	Retainer crown - 3/4 cast noble metal	\$50.00
D6790	Retainer crown - full cast high noble metal ⁴	\$50.00
D6791	Retainer crown - full cast predominantly base metal	\$50.00
D6792	Retainer crown - full cast noble metal	\$50.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	\$15.00
D7240	Removal of impacted tooth - completely bony	\$25.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$25.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$25.00
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) - <i>does not include pathology laboratory procedures</i>	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999**XI. ORTHODONTICS**

D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ⁵	\$1,400.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ⁵	\$1,400.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>dependent adult children to age 26</i>	\$1,400.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - <i>not to be charged with any other consultation procedure(s)</i> ¹	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ³	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$350.00

D9000-D9999**XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9986	Missed appointment - <i>without 24 hour notice</i>	\$5.00
D9987	Canceled appointment - <i>without 24 hour notice</i>	\$5.00
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review ..	No Cost

FOOTNOTES

- ¹ 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.
- ² Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$75.00.
- ³ Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$25.00 applies.
- ⁴ Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns (including titanium crowns), bridges, indirectly fabricated posts and cores, inlays and onlays.
- ⁵ Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 24 months of active treatment, an additional monthly fee of \$25.00 applies.

SCHEDULE B

Limitations of Benefits

1. Prophylaxis is limited to two treatments in a calendar year (includes periodontal maintenance).
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.
5. Denture relines are limited to one per denture during any 12 consecutive months.
6. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
8. Bitewing x-rays are limited to not more than one series of four films in any six month period.
9. Full mouth x-rays are limited to one set every 24 consecutive months.
10. Sealant benefits 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 up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
11. Accidental injury, except as noted in the Accident Injury Rider. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Exclusions of Benefits

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
4. Dental services performed in a hospital and related hospital fees.
5. Treatment of fractures and dislocations.
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
8. Any service that is not specifically listed as a covered expense.
9. 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.
10. Congenital malformations (e.g. congenitally missing teeth, supernumerary).
11. Cysts and malignancies, except as noted under *Schedule A, Description of Benefits and Copayments*.
12. Dispensing of drugs not normally supplied in a dental facility.

13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. "Specialist consultations" for noncovered benefits.
17. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
18. Crown lengthening procedures.

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Plan benefits cover 24 months of usual and customary orthodontic treatment.
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300 for dependent children to age 23. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. **Start-up fees are included in these amounts.**
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25.00 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.
8. 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, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. 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.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.

3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to a per office visit charge of \$25.00.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Transfer after banding has been initiated.
15. Lingually placed direct banded appliances, brackets and arch wires (invisible braces).

SCHEDULE C

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the Enrollee selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the two plans of treatment plus any copayment for covered procedures.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

1. PARTIAL DENTURES

A removable cast metal partial denture is considered an adequate restoration. If the Enrollee selects another course of treatment, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

If an cast metal partial denture will restore the case, the Contract Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the Enrollee and dentist may choose to use. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment plus any copayment for the covered benefit.

An acrylic partial denture is the covered benefit in cases involving extensive periodontal disease.

2. COMPLETE DENTURES

If, in the construction of a denture, the Enrollee and the Contract Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any five-year period. The Enrollee is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either relining or repair.

3. FILLINGS AND CROWNS

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

The DeltaCare USA program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatment. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a five-year period.

A pulp cap is a benefit only on a permanent tooth with an open apex.

4. FIXED BRIDGES

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 Enrollee'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. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement 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. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

5. RECONSTRUCTION

The DeltaCare USA program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare USA program. The program will allow for complete or partial denture(s).

6. SPECIALIZED TECHNIQUES

Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

7. PREVENTIVE CONTROL PROGRAMS

Any part of a preventive or soft tissue management program, which is not a listed covered service on Schedule A.

8. STAYPLATES

Stayplates are only a benefit to replace extracted anterior teeth for adults during a healing period and as anterior space maintainers for children.

9. FRENECTOMY

The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

10. PEDODONTIA

Pedodontic referrals must be preauthorized by Delta Dental. Benefits for dependent children to age 19 are covered at 100% of the Specialist's fee less any applicable copayments for covered benefits to a maximum of \$500 per child in a calendar year.

11. CORRECTION OF OCCLUSION

Selective equilibration of the dentition or restorations, not to include treatment of full mouth occlusal dysfunction.

12. TREATMENT PLANNING

The objective of this Program is to see that all Enrollees are brought to a good level of oral health and that this level of oral health is maintained. To achieve this objective takes careful treatment planning. Priorities have been established on the following basis:

- a. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee's overall oral health.
- b. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.
- c. Priority is then given to replacement of missing teeth not causing a gross lack of function.

Exceptions are made to this treatment planning concept based on individual circumstances.

"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.

Accident Injury Benefit

Delta Dental shall pay or otherwise discharge 100% of the Contract Dentist's "filed fees" not to exceed the "Prevailing Fee" as determined by Delta Dental or of Fees Actually Charged, whichever is less, less any applicable Enrollee copayments, for the following dental accident benefits:

Services described in the Schedule of Benefits and Copayments, Schedule A, and in paragraph II of this Rider, Schedule F are subject to the following maximum, limitation and exclusions when provided for conditions caused directly and independently of all other causes, by external, violent and accidental means.

I. DEFINITIONS

For the purpose of this Rider, the following additional definitions shall apply:

- A. "Attending Dentist's Statement" means the standard form used to file a claim.
- B. "Dental Accident Benefits" means those dental services which are provided under the terms of this Rider for conditions caused directly and independently of all other causes, by external, violent and accidental means.
- C. "Fee Actually Charged" means the "filed fee" for a particular dental service or procedure which a Contract Dentist reports to Delta Dental on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, rebated or which the Dentist does not in good faith attempt to collect.
- D. "Prevailing Fee" means the fee for a Single Procedure which satisfies the majority of Dentists in California, as determined by Delta Dental.
- E. "Single Procedure" means a dental procedure listed on a separate line in Schedule A and in paragraph II of this Rider, Schedule F.
- F. The term "filed fee" as used in this Rider shall have the following meaning:
"Filed Fee" means the Contract Dentist's fees on file with Delta Dental.

II. DENTAL ACCIDENT BENEFITS

For the purpose of this Rider, the following additional benefits shall apply:

- A. Intra-oral grafting
- B. Reimplantation
- C. Splinting
- D. Stayplate

III. MAXIMUM

The program shall provide Dental Accident Benefits for an Eligible Person up to a maximum of \$1,600 per Enrollee per any 12 month period.

IV. LIMITATION

Dental Accident Benefits shall be limited to services provided to an Eligible Person within 180 days following the date of accident, and shall not include any services for conditions caused by an accident occurring prior to the Enrollee's eligibility date.

V. EXCLUSIONS

The following services are not Dental Accident Benefits:

- A. Services for injuries or conditions which are benefits provided to the eligible Enrollee through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
- B. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- C. Services for restoring or stabilizing tooth structure lost from wear, or for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion. Such services include but are not limited to: equilibration and periodontal splinting.

Limitations and Exclusions of Benefits

- D. Prosthodontic services or any Single Procedure started prior to the date the Enrollee became eligible for such services under this Contract.
- E. Prescribed drugs, pre-medication or analgesia.
- F. Experimental procedures.
- G. Prophylaxis.
- H. All hospital costs and any additional fees charged by the Dentist for hospital treatment.
- I. Charges for general anesthesia.
- J. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- K. Implants (materials implanted into or on bone or soft tissue), the removal of implants or procedures related to the placement or removal of implants.
- L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- M. Replacement of existing restorations due to carious lesions.
- N. Orthodontic services (treatment of malalignment of teeth and/or jaws).

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- Review your plan benefits
- Access your ID card

Contact us

Need help? Let us know.

Online: Visit deltadentalins.com/csu and choose the “DeltaCare USA Customer Service” form.

Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 a.m. to 9 p.m., Eastern time. Or, use our automated phone system, available 24/7.

Underwritten by:

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.

This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the “Description of Benefits and Copayments” and “Limitations and Exclusions of Benefits” in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.