

DeltaCare[®] USA – provided by Delta Dental of California



We'll do **whatever it takes and then some.**

Find a DeltaCare USA dentist

Select from among the many conveniently located DeltaCare USA contracted general dentists. To find the most current listing of DeltaCare USA dental offices you can:

Visit our website at deltadentalins.com/enrollees. Under Find a dentist, select DeltaCare USA as your network.

Or call Customer Service at **800-422-4234** for help in finding a DeltaCare USA dentist.



Welcome to DeltaCare USA – quality, convenience, predictable costs

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

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

Enroll in DeltaCare USA and you'll enjoy these features:

Quality

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

Convenience

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

Predictable costs

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to \$100 per emergency
- No annual or lifetime dollar maximums except for accidental injury



Administered by Delta Dental Insurance Company



What if I have questions about my DeltaCare USA Program?

Eligibility for you and your family

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

Easy enrollment

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

How your DeltaCare USA program works

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

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

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

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

Provisions for emergency care

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-network dental emergencies. Your program pays up to \$100 for out-of-network emergency dental expenses per emergency for each enrollee.

My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists. With more than 3,800 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.

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

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

Can I change my contract dentist?

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

Can I have my teeth whitened under the DeltaCare USA program?

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

Highlights of your DeltaCare USA Program

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

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

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

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

Are pre-existing dental conditions and work in progress covered?

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

How does the DeltaCare USA program encourage preventive care?

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

Does my DeltaCare USA program cover specialists' services?

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

What if I have questions about my DeltaCare USA program?

Call Delta Dental Customer Service at 800-422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Our Customer Service representatives can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

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

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-2013 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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
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 - first radiographic image	No Cost
D0260	Extraoral - each additional 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
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 per 6 month period</i>	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	No Cost
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$5.00
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-cementation of space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D2000-D2999 III. RESTORATIVE		
<i>- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.</i>		
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 (<i>tooth colored</i>)	No Cost
D2331	Resin-based composite - two surfaces, anterior (<i>tooth colored</i>)	No Cost
D2332	Resin-based composite - three surfaces, anterior (<i>tooth colored</i>)	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (<i>tooth colored</i>)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior (<i>tooth colored</i>)	\$65.00
D2392	Resin-based composite - two surfaces, posterior (<i>tooth colored</i>)	\$75.00
D2393	Resin-based composite - three surfaces, posterior (<i>tooth colored</i>)	\$85.00
D2394	Resin-based composite - four or more surfaces, posterior (<i>tooth colored</i>)	\$95.00
D2510	Inlay - metallic - one surface ^{1, 2}	No Cost
D2520	Inlay - metallic - two surfaces ^{1, 2}	No Cost
D2530	Inlay - metallic - three or more surfaces ^{1, 2}	No Cost
D2542	Onlay - metallic - two surfaces ^{1, 2}	No Cost
D2543	Onlay - metallic - three surfaces ^{1, 2}	No Cost
D2544	Onlay - metallic - four or more surfaces ^{1, 2}	No Cost
D2610	Inlay - porcelain/ceramic - one surface ¹	\$250.00
D2620	Inlay - porcelain/ceramic - two surfaces ¹	\$300.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ¹	\$350.00
D2642	Onlay - porcelain/ceramic - two surfaces ¹	\$320.00
D2643	Onlay - porcelain/ceramic - three surfaces ¹	\$390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ¹	\$420.00
D2650	Inlay - resin-based composite - one surface (<i>tooth colored</i>) ¹	\$150.00
D2651	Inlay - resin-based composite - two surfaces (<i>tooth colored</i>) ¹	\$200.00
D2652	Inlay - resin-based composite - three or more surfaces (<i>tooth colored</i>) ¹	\$250.00
D2662	Onlay - resin-based composite - two surfaces (<i>tooth colored</i>) ¹	\$200.00
D2663	Onlay - resin-based composite - three surfaces (<i>tooth colored</i>) ¹	\$250.00
D2664	Onlay - resin-based composite - four or more surfaces (<i>tooth colored</i>) ¹	\$300.00
D2710	Crown - resin-based composite (indirect) ¹	\$35.00
D2710	Crown - resin-based composite (indirect) - (<i>molars</i>) ¹	\$185.00
D2712	Crown - ¾ resin-based composite (indirect) ¹	\$35.00
D2712	Crown - ¾ resin-based composite (indirect) - (<i>molars</i>) ¹	\$185.00
D2720	Crown - resin with high noble metal ¹	\$150.00
D2720	Crown - resin with high noble metal - (<i>molars</i>) ¹	\$300.00
D2721	Crown - resin with predominantly base metal ¹	\$50.00
D2721	Crown - resin with predominantly base metal - (<i>molars</i>) ¹	\$200.00
D2722	Crown - resin with noble metal ¹	\$50.00
D2722	Crown - resin with noble metal - (<i>molars</i>) ¹	\$200.00
D2740	Crown - porcelain/ceramic substrate ¹	\$50.00
D2740	Crown - porcelain/ceramic substrate - (<i>molars</i>) ¹	\$200.00
D2750	Crown - porcelain fused to high noble metal ¹	\$150.00
D2750	Crown - porcelain fused to high noble metal - (<i>molars</i>) ¹	\$300.00
D2751	Crown - porcelain fused to predominantly base metal ¹	\$50.00
D2751	Crown - porcelain fused to predominantly base metal - (<i>molars</i>) ¹	\$200.00
D2752	Crown - porcelain fused to noble metal ¹	\$50.00
D2752	Crown - porcelain fused to noble metal - (<i>molars</i>) ¹	\$200.00
D2780	Crown - ¾ cast high noble metal ¹	\$150.00
D2781	Crown - ¾ cast predominantly base metal ¹	\$50.00

D2782	Crown - $\frac{3}{4}$ cast noble metal ¹	\$50.00
D2783	Crown - $\frac{3}{4}$ porcelain/ceramic ¹	\$50.00
D2783	Crown - $\frac{3}{4}$ porcelain/ceramic - (<i>molars</i>) ¹	\$200.00
D2790	Crown - full cast high noble metal ¹	\$150.00
D2791	Crown - full cast predominantly base metal ¹	\$50.00
D2792	Crown - full cast noble metal ¹	\$50.00
D2794	Crown - titanium ¹	\$150.00
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
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior primary tooth</i>	\$5.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$5.00
D2940	Protective restoration	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 ²	No Cost
D2953	Each additional indirectly fabricated post - same tooth ²	No Cost
D2954	Prefabricated post and core in addition to crown	No Cost
D2957	Each additional prefabricated post - same tooth	No Cost
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	\$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$10.00
D2980	Crown repair necessitated by restorative material failure	\$10.00
D2981	Inlay repair necessitated by restorative material failure	\$10.00
D2982	Onlay repair necessitated by restorative material failure	\$10.00
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</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 dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	\$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$5.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) ³	\$45.00
D3320	<i>Root canal</i> - endodontic therapy, bicuspid tooth (excluding final restoration) ³	\$90.00
D3330	<i>Root canal</i> - endodontic therapy, molar (excluding final restoration) ³	\$125.00
D3346	Retreatment of previous root canal therapy - anterior ³	\$60.00
D3347	Retreatment of previous root canal therapy - bicuspid ³	\$105.00
D3348	Retreatment of previous root canal therapy - molar ³	\$140.00
D3410	Apicoectomy/periradicular surgery - anterior ³	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) ³	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root) ³	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root) ³	No Cost
D3430	Retrograde filling - per root ³	No Cost
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i> ³	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	\$75.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$30.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$30.00

D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$75.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$75.00
D4249	Clinical crown lengthening - hard tissue	\$75.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$45.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost
D5000-D5899 VI. PROSTHODONTICS (removable)		
D5110	Complete denture - maxillary ^{4, 5}	\$85.00
D5120	Complete denture - mandibular ^{4, 5}	\$85.00
D5130	Immediate denture - maxillary ^{4, 5}	\$110.00
D5140	Immediate denture - mandibular ^{4, 5}	\$110.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ^{4, 5}	\$80.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ^{4, 5}	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{4, 5}	\$110.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{4, 5}	\$110.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) ^{4, 5}	\$160.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) ^{4, 5}	\$160.00
D5410	Adjust complete denture - maxillary ⁴	No Cost
D5411	Adjust complete denture - mandibular ⁴	No Cost
D5421	Adjust partial denture - maxillary ⁴	No Cost
D5422	Adjust partial denture - mandibular ⁴	No Cost
D5510	Repair broken complete denture base	\$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$5.00
D5610	Repair resin denture base	\$15.00
D5620	Repair cast framework	\$15.00
D5630	Repair or replace broken clasp	\$15.00
D5640	Replace broken teeth - per tooth	\$5.00
D5650	Add tooth to existing partial denture	\$5.00
D5660	Add clasp to existing partial denture	\$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$75.00
D5710	Rebase complete maxillary denture ⁶	\$35.00
D5711	Rebase complete mandibular denture ⁶	\$35.00
D5720	Rebase maxillary partial denture ⁶	\$35.00
D5721	Rebase mandibular partial denture ⁶	\$35.00
D5730	Reline complete maxillary denture (chairside) ⁶	No Cost
D5731	Reline complete mandibular denture (chairside) ⁶	No Cost
D5740	Reline maxillary partial denture (chairside) ⁶	No Cost
D5741	Reline mandibular partial denture (chairside) ⁶	No Cost
D5750	Reline complete maxillary denture (laboratory) ⁶	\$25.00
D5751	Reline complete mandibular denture (laboratory) ⁶	\$25.00
D5760	Reline maxillary partial denture (laboratory) ⁶	\$25.00

D5761	Reline mandibular partial denture (laboratory) ⁶	\$25.00
D5820	Interim partial denture (maxillary) ⁴	No Cost
D5821	Interim partial denture (mandibular) ⁴	No Cost
D5850	Tissue conditioning, maxillary ^{4, 6}	No Cost
D5851	Tissue conditioning, mandibular ^{4, 6}	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 ⁷	\$150.00
D6211	Pontic - cast predominantly base metal ⁷	\$50.00
D6212	Pontic - cast noble metal ⁷	\$50.00
D6240	Pontic - porcelain fused to high noble metal ⁷	\$150.00
D6240	Pontic - porcelain fused to high noble metal - (molars) ⁷	\$300.00
D6241	Pontic - porcelain fused to predominantly base metal ⁷	\$50.00
D6241	Pontic - porcelain fused to predominantly base metal - (molars) ⁷	\$200.00
D6242	Pontic - porcelain fused to noble metal ⁷	\$50.00
D6242	Pontic - porcelain fused to noble metal - (molars) ⁷	\$200.00
D6245	Pontic - porcelain/ceramic ⁷	\$50.00
D6245	Pontic - porcelain/ceramic - (molars) ⁷	\$200.00
D6250	Pontic - resin with high noble metal ⁷	\$150.00
D6250	Pontic - resin with high noble metal - (molars) ⁷	\$300.00
D6251	Pontic - resin with predominantly base metal ⁷	\$50.00
D6251	Pontic - resin with predominantly base metal - (molars) ⁷	\$200.00
D6252	Pontic - resin with noble metal ⁷	\$50.00
D6252	Pontic - resin with noble metal - (molars) ⁷	\$200.00
D6600	Inlay - porcelain/ceramic, two surfaces ⁷	\$300.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ⁷	\$350.00
D6602	Inlay - cast high noble metal, two surfaces ⁷	\$100.00
D6603	Inlay - cast high noble metal, three or more surfaces ⁷	\$100.00
D6604	Inlay - cast predominantly base metal, two surfaces ⁷	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces ⁷	No Cost
D6606	Inlay - cast noble metal, two surfaces ⁷	No Cost
D6607	Inlay - cast noble metal, three or more surfaces ⁷	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces ⁷	\$320.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ⁷	\$390.00
D6610	Onlay - cast high noble metal, two surfaces ⁷	\$100.00
D6611	Onlay - cast high noble metal, three or more surfaces ⁷	\$100.00
D6612	Onlay - cast predominantly base metal, two surfaces ⁷	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces ⁷	No Cost
D6614	Onlay - cast noble metal, two surfaces ⁷	No Cost
D6615	Onlay - cast noble metal, three or more surfaces ⁷	No Cost
D6720	Crown - resin with high noble metal ⁷	\$150.00
D6720	Crown - resin with high noble metal - (molars) ⁷	\$300.00
D6721	Crown - resin with predominantly base metal ⁷	\$50.00
D6721	Crown - resin with predominantly base metal - (molars) ⁷	\$200.00
D6722	Crown - resin with noble metal ⁷	\$50.00
D6722	Crown - resin with noble metal - (molars) ⁷	\$200.00
D6740	Crown - porcelain/ceramic ⁷	\$50.00
D6740	Crown - porcelain/ceramic - (molars) ⁷	\$200.00
D6750	Crown - porcelain fused to high noble metal ⁷	\$150.00
D6750	Crown - porcelain fused to high noble metal - (molars) ⁷	\$300.00
D6751	Crown - porcelain fused to predominantly base metal ⁷	\$50.00

D6751	Crown - porcelain fused to predominantly base metal - (<i>molars</i>) ⁷	\$200.00
D6752	Crown - porcelain fused to noble metal ⁷	\$50.00
D6752	Crown - porcelain fused to noble metal - (<i>molars</i>) ⁷	\$200.00
D6780	Crown - ¾ cast high noble metal ⁷	\$150.00
D6781	Crown - ¾ cast predominantly base metal ⁷	\$50.00
D6782	Crown - ¾ cast noble metal ⁷	\$50.00
D6783	Crown - ¾ porcelain/ceramic ⁷	\$50.00
D6783	Crown - ¾ porcelain/ceramic - (<i>molars</i>) ⁷	\$200.00
D6790	Crown - full cast high noble metal ⁷	\$150.00
D6791	Crown - full cast predominantly base metal ⁷	\$50.00
D6792	Crown - full cast noble metal ⁷	\$50.00
D6930	Recent fixed partial denture	No Cost
D6940	Stress breaker ⁷	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	\$10.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of 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	\$40.00
D7240	Removal of impacted tooth - completely bony	\$50.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$70.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$70.00
D7286	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
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	\$50.00
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

D8050	Interceptive orthodontic treatment of the primary dentition ⁸	\$1,400.00
D8060	Interceptive orthodontic treatment of the transitional dentition ⁸	\$1,400.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ⁸	\$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ⁸	\$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> ⁸	\$1,800.00
D8660	Pre-orthodontic treatment visit - <i>not to be charged with any other consultation procedure(s)</i> ⁹	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable retainers</i>) ¹⁰	\$250.00
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes	\$250.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$100.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$250.00

D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$100.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$5.00
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	\$150.00
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00

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

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

Emergency Services - The Contract Dentist is responsible for providing covered emergency dental care while an Enrollee is within 35 miles of the contract facility. If an Enrollee is more than 35 miles from the Contract Dentist's facility, Delta Dental will reimburse the Enrollee for the cost of covered emergency dental care, less any applicable Enrollee copayments, to a maximum of \$100.00 per enrollee, per emergency. All services are subject to the limitations and exclusions of the program.

Accident Injury Benefit - this program provides coverage for dental accident injuries up to 100 percent of the Dentist's usual fee, less any applicable Enrollee copayments, to a maximum of \$1,600.00 per Enrollee, in any 12-month period. The benefit is subject to the limitations and exclusions of the program.

FOOTNOTES

- 1 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*
- 2 *Base or noble metal is the benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgrade.*
- 3 *A benefit for permanent teeth only.*
- 4 *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.*
- 5 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*
- 6 *Limited to 1 per denture during any 12 consecutive months.*
- 7 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*
- 8 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee), and D8680 (Orthodontic retention). Beyond 24 months, an additional monthly fee not to exceed \$125.00 applies.*
- 9 *In the event orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*
- 10 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee not to exceed \$125.00 applies.*

SCHEDULE B

Limitations of Benefits

1. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
5. 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 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.
6. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
7. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling. Replacement of an existing crown, inlay or onlay that is non-functional or non-restorable is a benefit when the existing restoration is five+ years old.
8. 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.
9. A covered metallic inlay, onlay, or indirectly fabricated post and core using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is \$100.00 per tooth.
10. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
11. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth with pathology.
12. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
13. Clinical crown lengthening - hard tissue is limited to one per tooth per lifetime.
14. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
16. Coverage for the placement of a fixed partial denture ("bridge") is limited to:
 - a. The initial placement of a bridge when all the following conditions are present:
 - a single permanent tooth requires prosthetic replacement.
 - the abutment teeth can adequately support and retain a new bridge.
 - the missing tooth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture.
 - no other missing teeth in the same arch require prosthetic replacement with a new removable partial denture; and (*for a bridge replacing a posterior tooth*) one or more of the abutment teeth meet Limitation #7.
 - b. The replacement of an existing bridge that is not serviceable due to decay, fracture or other non-cosmetic defect, if:
 - the existing bridge is at least five years old; **and**
 - the same abutment teeth can adequately support and retain a new bridge; **and**
 - no other missing teeth in the same arch require prosthetic replacement.
17. Coverage for a new removable partial or complete denture is limited to:
 - a. The initial placement of removable partial or complete denture in an arch when:
 - one or more permanent teeth require prosthetic replacement; **and**
 - the missing tooth/teeth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture; **and**
 - (for partial dentures only) there are suitable abutment teeth to retain and support a removable partial denture.
 - b. The replacement of an existing removable partial or complete denture with non-cosmetic defect(s) that cause the denture to be non-serviceable if:
 - the existing removable denture is at least five years old; **and**
 - the existing removable denture cannot be made serviceable by adjustment, repair, relining or rebasing.

18. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
19. 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.
20. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
21. Retained primary teeth shall be covered as primary teeth.
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
23. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
24. External bleaching is limited to fabrication of one bleaching tray per arch; bleaching gel for two weeks of patient self treatment; and no more than one treatment per arch, per 36 months.
25. 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.
26. Soft tissue management programs include, but are not limited to, periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for covered services.
27. Emergency Services - The Contract Dentist is responsible for providing covered emergency dental care while an Enrollee is within 35 miles of the Contract Dentist's facility. If an Enrollee requires emergency dental care and is more than 35 miles from the Contract Dentist's facility, then Delta Dental will reimburse the Enrollee for the cost of covered emergency dental care, less any applicable Enrollee copayments, to a maximum of \$100.00 per Enrollee, per emergency. Emergency dental care is limited to listed procedures required to alleviate severe pain, swelling and/or bleeding or to avoid placing the Enrollee's health in serious jeopardy. Any further treatment of the cause of such emergency dental care must be preauthorized by Delta Dental or provided by the assigned Contract Dentist. All services are subject to the limitations and exclusions of the program.
28. Accident Injury Benefit - An accident injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

Delta Dental will pay up to 100 percent of the Dentist's usual fee, for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a maximum of \$1,600.00 in any 12-month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*: 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 are subject to *Schedule B, Limitations and Exclusions of Benefits*, excluding Limitations #7, 16, and 17. Benefits are limited to services provided as a result of an accident that occurred:

- a. while the Enrollee was covered under the DeltaCare USA program, **or**
 - b. while the Enrollee was covered under another DeltaCare USA program, provided benefits for the expenses incurred would have been paid had the Enrollee continued to be eligible under that program.
29. 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 fee" for the covered procedure, plus any applicable Copayment for the covered procedure.

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

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.

2. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. 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).
6. 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.
7. 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.
8. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
9. Extraction/removal of an erupted, partially erupted or impacted tooth:
 - a. Solely for orthodontic purposes.
 - b. When the tooth exhibits no signs or symptoms of infection, cystic degeneration, fracture, caries and/or having caused damage to an adjacent tooth; **or**
 - c. When the extraction or removal would be inconsistent with generally accepted professional standards.
10. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
11. Consultations for non-covered benefits.
12. Replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or better match bleached teeth.
13. Dental services received from any dental facility other than the assigned Contract Dentist, including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at 800-422-4234.
14. 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.
15. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
16. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
17. Dispensing of drugs not normally utilized in the delivery of dental services.
18. 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 provision).
19. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
20. 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.

Orthodontic Limitations

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

1. Orthodontic treatment must be provided by the selected Contract Orthodontist.
2. Orthodontic Copayments are listed on *Schedule A, Description of Benefits and Copayments* for both interceptive and comprehensive orthodontic treatment. Additional fees will be charged for start-up and retention.
3. Benefits cover 24 months of active interceptive orthodontic treatment.
4. Benefits cover 24 months of active comprehensive orthodontic treatment, including initial banding, de-banding and any commonly used appliances such as headgear.
5. Following benefited interceptive or comprehensive orthodontic treatment, retention is covered up to a maximum of 24 months. Retention includes the initial construction, placement and adjustment to removable retainers and office visits.
6. Treatment plans extending beyond 24 months of active interceptive or comprehensive orthodontic treatment, or 24 months of retention, will be subject to a monthly office visit fee to the Enrollee not to exceed \$125.00 per month.
7. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall increase to a maximum of \$2,800.00 for Enrollees and covered dependents to age 19 and \$3,000.00 for Enrollees and covered dependents over age 19. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.
8. 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.
9. 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.
10. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
 - a. will not be entitled to a refund of any amounts previously paid; **and**
 - b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
11. Coverage and treatment under this Program are conditioned on patients following the treatment plan recommended by their Contract Orthodontist. Failure to follow the instructions of the Contract Orthodontist can compromise the health of teeth and/or gums, which may necessitate discontinuation of treatment. Patients who are required to restart their orthodontic treatment because of non-compliance with the treatment plan will be subject again to all applicable Copayments.
12. 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 that include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Changes in treatment necessitated by accident of any kind.
4. Surgical procedures incidental to orthodontic treatment.
5. Myofunctional therapy.
6. Surgical procedures related to cleft palate, micrognathia or macrognathia.
7. Treatment related to temporomandibular joint disturbances.

8. Supplemental appliances not routinely used in comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.
9. Restorative work caused by orthodontic treatment.
10. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.
11. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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DeltaCare USA Customer Service

800-422-4234

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.**

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. These companies are financially responsible for their own products.

Customer Service

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

Provided by:

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Cerritos, CA 90703

Administered by:

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P.O. Box 1803
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