DeltaCare® USA

Quality Care for You and Your Family

Disclosure Form/Contract

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

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

DISCLOSURE FORM/CONTRACT ("CONTRACT")

This booklet is a Disclosure Form/Contract ("Contract") for your DeltaCare USA Individual/Family Dental Program ("Program") provided by:

Delta Dental of California ("Delta Dental")
a Specialized Health Care Service Plan
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

This booklet discloses the terms and conditions of the Program available in California. **PLEASE READ THE ENTIRE DOCUMENT COMPLETELY AND CAREFULLY.** You have a right to review this Contract prior to enrollment. Persons with special health care needs should read, completely and carefully, the section entitled "Special Needs".

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALTY SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST. A matrix describing the Program's major Benefits and coverage can be found on the following page.

ADDITIONAL INFORMATION ABOUT YOUR BENEFITS IS AVAILABLE BY CALLING THE CUSTOMER SERVICE DEPARTMENT AT 800-422-4234, 5 a.m. - 6 p.m., PACIFIC TIME, MONDAY THROUGH FRIDAY.

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider (Contract Dentist) may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-422-4234 or your insurance broker, if applicable. To fully understand your coverage, you may wish to carefully review this Disclosure Form/Contract.

Information Concerning Benefits Under The DeltaCare USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS DISCLOSURE FORM/CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Schedule of Benefits and Copayments, subject to the limitations and exclusions of the Program. Copayments range by category of service. Examples are as follows: Diagnostic Services: No Cost - $25.00 Preventive Services: No Cost - $85.00 Restorative Services: $10.00 - $495.00 Endodontic Services: $10.00 - $725.00 Periodontic Services: $64.00 - $650.00 Prosthodontic Services Removable: $24.00 - $700.00 Prosthodontic Services Fixed: $30.00 - $495.00 Oral and Maxillofacial Surgery: $35.00 - $230.00 Orthodontic Services: No Cost - $2,900.00 Adjunctive General Services: No Cost - $125.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to once in each six month period; replacement of removable and fixed dentures and crowns is limited to once in any five year period.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit up to $100.00 per emergency, per Enrollee, for out-of-area Emergency Services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the Program, has a specific Copayment that is shown in the *Description of Benefits and Copayments* in this Contract..

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Definitions

As used in this Disclosure Form/Contract:

Administrator means Delta Dental Insurance Company, a third party entity designated to perform administrative functions described throughout the Contract and in this booklet, including, but not limited to, the collection of Premium and eligibility.

Applicant means the individual contracting to obtain dental Benefits as the Primary Enrollee. YOU or YOUR refers to the Applicant.

Benefits mean those dental services that are provided under the terms of this Contract and described in this booklet.

Contract means this agreement between Delta Dental and the Applicant including the *Enrollment and Payment Authorization Form*, the attached schedules, and any appendices, endorsements or riders. This Contract constitutes the entire agreement between the parties.

Contract Dentist means a Dentist who provides services in general dentistry, and has agreed to provide Benefits under this Program.

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

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

Contract Term means the one-year period starting on the Effective Date and each annual renewal period during which the Contract remains in effect.

Copayment means the amount listed in *Schedule A* paid by an Enrollee to a Contract Dentist or Contract Specialist for the Benefits provided under this Program. Enrollees are responsible for payment of all Copayments at the time treatment is received.

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

Domestic Partner means a person who, together with the primary Enrollee, has affirmed a domestic partnership through an affidavit of domestic partnership provided to Delta Dental.

Effective Date means the first day of the month following Delta Dental's timely receipt of Premium and the *Enrollment and Payment Authorization Form*.

Eligible Dependent means any dependent of a primary Enrollee who is eligible for Benefits as described in this booklet.

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (1) placing the Enrollee's dental health in serious jeopardy, or (2) serious impairment to dental functions.

Enrollee means a person enrolled to receive Benefits including the Primary Enrollee and Eligible Dependent(s).

Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under the terms of this Contract.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Premium means the amount payable as provided in this Contract.

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

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

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be preauthorized by Delta Dental.

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

We, Us or Our means Delta Dental of California or the Administrator as appropriate.

What is the DeltaCare USA Individual/Family Dental Program ("Program")?

The DeltaCare USA Individual/Family Dental Program ("Program") provides comprehensive dental care through a convenient network of Contract Dentists in the State of California. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

How to use the DeltaCare USA Program/Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist from the list of dental facilities furnished with this Contract. You must indicate the Contract Dentist's name and facility ID # on the *Enrollment and Payment Authorization Form*. YOU AND YOUR ELIGIBLE DEPENDENTS MAY OBTAIN TREATMENT FROM ANY CONTRACT DENTIST AT THE SAME FACILITY.

Shortly after enrollment, you will receive a DeltaCare USA membership packet that tells you the Effective Date of your coverage. The packet will also show the address and telephone number of your Contract Dentist. You may obtain covered dental services any time after your Effective Date. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Contract Dentists should be directed to the Customer Service department at 800-422-4234.

YOU AND YOUR ELIGIBLE DEPENDENTS MUST GO TO YOUR ASSIGNED CONTRACT DENTIST TO OBTAIN BENEFITS EXCEPT FOR EMERGENCY SERVICES OR SPECIALIST SERVICES PREAUTHORIZED BY US AS DESCRIBED BELOW. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

Who is eligible for coverage?

You and your Eligible Dependents, as defined below, are eligible provided you live or work in the DeltaCare USA service area. You and your Eligible Dependents become eligible:

1) on the first day of the month following our receipt of timely Premium and complete enrollment information;
2) as soon as they become your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Your Eligible Dependents include:

1) spouse (unless legally separated or divorced) or Domestic Partner (until such partnership is terminated by either or both parties);
2) children from birth up to age 26.

Children include natural children, stepchildren, adopted children, foster children and children of a Domestic Partner. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Foster children and legally adopted children (other than newborns) are eligible from and after the moment they are placed in your physical custody. Dependents in military service are not eligible.

A child over the age of 26 may remain eligible if that child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition and is chiefly dependent on you for support and maintenance. See the *Renewal, Cancellation and Termination of Benefits* section for more information.

How do I enroll?

First, please read all the information contained in this Contract (particularly the *Schedule of Benefits and Copayments*, limitations and exclusions). This way you will know what procedures are covered and what your Copayments and Premium will be. Second, from the network directory, choose a dental facility that is convenient for you and for your family's treatment. Third, complete the *Enrollment and Payment Authorization Form* and indicate which contract facility you have chosen.

Remember - enrollment is for a minimum of twelve (12) months. If coverage is voluntarily discontinued, you and your eligible dependents may not re-enroll during the 12-month period immediately following the voluntary termination.

How much do I pay?

The annual Premium for the initial Contract Term is:

* Enrollee only (one person): $80.76
  plus a one-time enrollment fee of $10.00

* Enrollee and one dependent (spouse or child): $130.68
  plus a one-time enrollment fee of $10.00

* Enrollee and two or more dependents: $191.16
  plus a one-time enrollment fee of $10.00

A full refund of Premium, including the one time enrollment fee, is available if the written request for refund is made within the first month of the Contract Term. Thereafter, requests for Premium refund will be pro-rated based upon the number of months remaining in the Contract Term subject to the following conditions:

1) the one-time enrollment fee is not refundable after the first month of coverage;
2) you, or your covered dependents, have not received any Benefits under the DeltaCare USA program; and
3) there is at least one month remaining in the Contract Term.

Coverage is based on a full calendar month. There are no partial month refunds.

Choose a Payment Option

For your convenience, Delta Dental has made it possible to choose from two payment options. The annual Premium may be charged to your MasterCard, Visa, Discover or American Express account, or you may pay by personal check or money order. Be sure to indicate which payment option you have chosen on the *Enrollment and Payment Authorization Form*.

* **Credit Card Payment Option**

  If you choose the Credit Card Payment Option, your annual Premium and the $10.00 one-time enrollment fee will be charged to your MasterCard, Visa, Discover or American Express account.

* **Check/Money Order Payment Option**

  If you prefer to pay by personal check or money order, select that option on the *Enrollment and Payment Authorization Form* and make your check payable to Delta Dental of California. Checks returned for insufficient funds are subject to a $25.00 processing fee which must be paid before coverage will be reinstated.

Mailing Instructions

Please mail the completed *Enrollment and Payment Authorization Form* with either credit card information or a check or money order for the Premium and the $10.00 enrollment fee to:

Delta Dental of California
P.O. Box 660138
Dallas, TX 75266-0138

What will my Effective Date be?

We must receive the enrollment materials by the 21st day of the month for coverage to start the first day of the following month. If we receive the enrollment materials after the 21st day of the month, coverage will begin the first day of the second month.

Emergency Services

Your assigned Contract Dentist maintains a 24-hour Emergency Services system seven days a week. If Emergency Services are needed, you should contact your Contract Dentist whenever possible. Benefits for Emergency Services by any other Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or is unable to see you within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

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

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry, must be 1) referred by the assigned Contract Dentist, and 2) preauthorized in writing by us. You pay the specified Copayment. (Refer to *Schedule A*.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive written Preauthorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not preauthorized by Delta Dental may not be covered.

If the services of a Contract Orthodontist are needed, please refer to Section XI, Orthodontics in *Schedule A*, and limitations and exclusions in *Schedule B*, to determine Benefits.

If you are referred to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Special Needs

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

Facility Accessibility

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

What if I need to change Contract Dentists?

You may change your assigned Contract Dentist by directing a request to the Customer Service department or by visiting our website at deltadentalins.com. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, a change in Contract Dentist must be requested before the 21st day of the month to be effective on the first day of the following month. We will provide an Enrollee written notice of assignment to another Contract Dentist facility near the Enrollee's home, if 1) a selected facility is closed to further enrollment, 2) a chosen Contract Dentist withdraws from the Program, or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another Contract Dentist. All

Treatment in Progress must be completed before you change to another Contract Dentist. For example, this would include 1) partial or full dentures for which final impressions have been taken, 2) completion of root canals in progress and 3) delivery of crowns when teeth have been prepared.

If your assigned Contract Dentist terminates participation in this Program, that Contract Dentist will complete all Treatment in Progress as described above.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in *Schedule A* subject to the limitations and exclusions described in *Schedule B*. Benefits are only available in the state of California. The services are performed as deemed appropriate by your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A*. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in *Schedule A*.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, every contract between Delta Dental and our Contract Dentists contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental.

If you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services. For further clarification see *Emergency Services* and *Specialist Services*.

Dentist Compensation

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

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

Second Opinion

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent

and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-422-4234 or write to Delta Dental.

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

Claims for Reimbursement

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

Processing Policies

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

Enrollee Complaint Procedure

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

Quality Management Department

P.O. Box 6050

Artesia, CA 90702

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

Within 5 calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

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

IMR is generally not applicable to a dental plan, unless that dental plan covers services related to the practice of medicine or is offered pursuant to a contract with a health plan providing medical, surgical or hospital services.

Renewal, Cancellation and Termination of Benefits

No change in Benefits or Premium will be made during a Contract Term. We will send you a written renewal notice, including any proposed changes in Benefits and/or Premium at least 30 days before your coverage expires. Your coverage will terminate at the end of the Contract Term unless you renew by paying the applicable Premium on or before the expiration date of your Contract.

Receipt of the applicable Premium by us after termination of your coverage will reinstate your coverage unless payment is received more than 15 days after termination and we refund such payment within 20 business days. If reinstatement is not requested within 15 days of termination, you must wait 12 months before you may re-enroll in the program.

Enrollment will be cancelled by Delta Dental in the following events:

1) for any Eligible Dependent, immediately upon receipt of a written notice regarding the loss of dependent status; however, a dependent child may continue eligibility if:
    a) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age,
    b) he or she is chiefly dependent on you for support, and
    c) proof of dependent's disability or incapacity is provided within 60 days of request by Delta Dental and subsequently as required. Such requests will not be made more than once a year following a two year period after the Eligible Dependent reaches age 26. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age;
2) upon 15 days written notice if:
    a) the Enrollee is guilty of misconduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
    b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits;
3) upon 30 days written notice if the Enrollee fails to pay Copayments; provided, however, that the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges.

Coverage for an Enrollee will terminate as of the date enrollment is cancelled under the terms of this Disclosure Form/Contract. However, we will continue to provide Benefits for completion of any Treatment in Progress (less any applicable Copayment). Cancellation of a Primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in this booklet.

An Enrollee who believes that enrollment has been cancelled or not renewed because of dental condition or the need for dental care may request a review of the cancellation by the Director of the Department of Managed Health Care of the State of California. Please refer to the *Enrollee Complaint Procedure* section for more information.

Entire Contract

This Disclosure Form/Contract, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement governing the Program.

No amendment is valid unless approved by an executive officer of Delta Dental and attached to this booklet. No agent or broker has authority to amend this Contract or waive any of its provisions.

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service Department, P.O. Box 1803, Alpharetta, GA 30023.

Governing Law

This Program is a health care service plan subject to the requirements of Chapter 22 of Division 2 of the California Health & Safety Code and Chapter 1 of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be included in this Disclosure Form/Contract by the above law and regulation binds this Program whether or not stated.

Delta Dental shall comply in all respects with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable enrollee information. Both parties agree that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplification, security or privacy laws or regulations.

DeltaCare® USA

DeltaCare USA INDIVIDUAL/FAMILY DENTAL PROGRAM CAA55 ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Broker #: 4378

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
(800) 422-4234

I understand that, if I have indicated that coverage under the Program is to be provided only for the dependent child(ren) named on this form, I am responsible for payment of the required annual Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

I understand that I must select a DeltaCare USA Contract Dentist from the list of dental facilities. If the selected facility is not available, non-contracted or closed to further enrollment, Delta Dental reserves the right to assign me to another dental office as close as possible to my home. In the event that Delta Dental cannot assign me to a Contract Dentist my premium will be refunded.

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dentalís ratio of health care expense to premiums received for the last calendar year, with respect to the DeltaCare USA Individual/Family Dental Program, was 67.91%.

Applicant/Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY
(To add additional dependents please attach a separate sheet)

Name: Last ____ First ____ MI ____

Mailing Address: Address ____

City ____ State ____ Zip ____

Date of Birth: Month ____ Day ____ Year ____

❑ Male
❑ Female

Home Phone # ____

SSN/ID #: ____

E-mail ____

For internal use only

Contract Facility Name: ____

Contract Facility # ____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female	Date of Birth
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	

* Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

Spouse - SP **Domestic Partner - DP** **Child - CH** **Other Child - OC**

PROGRAM COST AND PAYMENT OPTION (choose only one)

Check appropriate box based on the information below:

	Plan CAA55
❑ Individual annual Premium	**$ 80.76**
❑ Individual plus one dependent annual Premium	**$130.68**
❑ Individual plus two or more dependents annual Premium	**$191.16**
One-time non refundable Enrollment Fee (required for new enrollment)	**$ 10.00**
TOTAL	**$________**

Indicate effective date: ___ ___ (Month) ___ ___ (Day) ___ ___ ___ ___ (Year)

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.

I wish to enroll in the DeltaCare USA Individual/Family Dental Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

PAYMENT OPTIONS

❑ CHECK/MONEY ORDER PAYMENT OPTION
Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

❑ CREDIT CARD PAYMENT OPTION

❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

CARD # ______________________________

EXPIRATION DATE ______________________________

NAME AS IT APPEARS ON THE CARD

____

SIGNATURE ______________________________

DATE ______________________________

By signing above you authorize Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

Note: Any credit card refunds under the Program may be made by check or credit card.

Signature: ______________________________ Date ______________________________

Return form to Delta Dental of California at P.O. BOX 660138, Dallas, TX 75266-0138 or enroll online at www.deltadentalins.com

CAA55

SCHEDULE A

Description of Benefits and Copayments

The benefits shown below are performed as needed and deemed necessary 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-2014 procedure codes, descriptors or nomenclature which 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 regulations.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	$25.00
D0220	Intraoral - periapical first radiographic image	$5.00
D0230	Intraoral - periapical each additional radiographic image	$3.00
D0240	Intraoral - occlusal radiographic image	$8.00
D0250	Extraoral - first radiographic image	$8.00
D0260	Extraoral - each additional radiographic image	$5.00
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings two radiographic images - *limited to 1 series every 6 months*	No Cost

Code	Description	Cost
D0273	Bitewings three radiographic images - *limited to 1 series every 6 months*	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	$15.00
D0330	Panoramic radiographic image - *limited to 1 every 24 months*	$25.00
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	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 - *available only when performed in conjunction with a covered biopsy*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$15.00

D1000-D1999 II. PREVENTIVE

Code	Description	Cost
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	$25.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	$25.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 per 6 month period*	$25.00
D1208	Topical application of fluoride - *child to age 19; 1 per 6 month period*	$25.00
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$25.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$25.00
D1510	Space maintainer - fixed - unilateral	$85.00
D1515	Space maintainer - fixed - bilateral	$85.00
D1520	Space maintainer - removable - unilateral	$85.00
D1525	Space maintainer - removable - bilateral	$85.00
D1550	Re-cementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

D2000-D2999 III. RESTORATIVE

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

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

Code	Description	Fee
D2140	Amalgam - one surface, primary or permanent	$30.00
D2150	Amalgam - two surfaces, primary or permanent	$45.00
D2160	Amalgam - three surfaces, primary or permanent	$55.00
D2161	Amalgam - four or more surfaces, primary or permanent	$60.00
D2330	Resin-based composite - one surface, anterior	$70.00
D2331	Resin-based composite - two surfaces, anterior	$80.00
D2332	Resin-based composite - three surfaces, anterior	$90.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$120.00
D2390	Resin-based composite crown, anterior	$120.00
D2391	Resin-based composite - one surface, posterior	$75.00
D2392	Resin-based composite - two surfaces, posterior	$85.00
D2393	Resin-based composite - three surfaces, posterior	$120.00
D2394	Resin-based composite - four or more surfaces, posterior	$125.00
D2510	Inlay - metallic - one surface [1]	$260.00
D2520	Inlay - metallic - two surfaces [1]	$270.00
D2530	Inlay - metallic - three or more surfaces [1]	$280.00
D2542	Onlay - metallic - two surfaces [1]	$270.00
D2543	Onlay - metallic - three surfaces [1]	$290.00
D2544	Onlay - metallic - four or more surfaces [1]	$300.00
D2610	Inlay - porcelain/ceramic - one surface [2]	$350.00
D2620	Inlay - porcelain/ceramic - two surfaces [2]	$385.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [2]	$405.00
D2642	Onlay - porcelain/ceramic - two surfaces [2]	$415.00
D2643	Onlay - porcelain/ceramic - three surfaces [2]	$415.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [2]	$425.00
D2650	Inlay - resin-based composite - one surface [2]	$250.00
D2651	Inlay - resin-based composite - two surfaces [2]	$275.00
D2652	Inlay - resin-based composite - three or more surfaces [2]	$310.00
D2662	Onlay - resin-based composite - two surfaces [2]	$305.00
D2663	Onlay - resin-based composite - three surfaces [2]	$330.00
D2664	Onlay - resin-based composite - four or more surfaces [2]	$375.00
D2710	Crown - resin-based composite (indirect) [2]	$125.00
D2712	Crown - ¾ resin-based composite (indirect) [2]	$125.00
D2720	Crown - resin with high noble metal [2]	$425.00
D2721	Crown - resin with predominantly base metal [2]	$325.00
D2722	Crown - resin with noble metal [2]	$425.00

Code	Description	Fee
D2740	Crown - porcelain/ceramic substrate [2, 3]	$495.00
D2750	Crown - porcelain fused to high noble metal [2, 3, 4]	$425.00
D2751	Crown - porcelain fused to predominantly base metal [2, 4]	$325.00
D2752	Crown - porcelain fused to noble metal [2, 4]	$425.00
D2780	Crown - ¾ cast high noble metal	$425.00
D2781	Crown - ¾ cast predominantly base metal	$325.00
D2782	Crown - ¾ cast noble metal	$425.00
D2783	Crown - ¾ porcelain/ceramic [2, 3]	$495.00
D2790	Crown - full cast high noble metal	$425.00
D2791	Crown - full cast predominantly base metal	$325.00
D2792	Crown - full cast noble metal	$425.00
D2794	Crown - titanium	$495.00
D2910	Recement inlay, onlay or partial coverage restoration	$15.00
D2915	Recement cast or prefabricated post and core	$15.00
D2920	Recement crown	$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$120.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior primary tooth*	$95.00
D2930	Prefabricated stainless steel crown - primary tooth	$55.00
D2931	Prefabricated stainless steel crown - permanent tooth	$55.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$95.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$95.00
D2940	Protective restoration	$10.00
D2941	Interim therapeutic restoration - primary dentition	$10.00
D2949	Restorative foundation for an indirect restoration	$90.00
D2950	Core buildup, including any pins when required	$90.00
D2951	Pin retention - per tooth, in addition to restoration	$30.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [1]	$85.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [1]	$50.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$75.00
D2955	Post removal	$40.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$45.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$35.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$65.00
D2980	Crown repair necessitated by restorative material failure	$50.00
D2981	Inlay repair necessitated by restorative material failure	$50.00

D2982	Onlay repair necessitated by restorative material failure	$50.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$25.00

D3000-D3999 IV. ENDODONTICS

- With the exception of pulp caps, pulpotomies, pulpal debridements, and pulpal therapies with resorbable fillings, all endodontic procedures listed below are benefits for permanent teeth only.

D3110	Pulp cap - direct (excluding final restoration)	$10.00
D3120	Pulp cap - indirect (excluding final restoration)	$10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$45.00
D3221	Pulpal debridement, primary and permanent teeth	$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$45.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$240.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration)	$350.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration)	$400.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$240.00
D3346	Retreatment of previous root canal therapy - anterior	$500.00
D3347	Retreatment of previous root canal therapy - bicuspid	$600.00
D3348	Retreatment of previous root canal therapy - molar	$725.00
D3410	Apicoectomy - anterior	$470.00
D3421	Apicoectomy - bicuspid (first root)	$535.00
D3425	Apicoectomy - molar (first root)	$580.00
D3426	Apicoectomy (each additional root)	$115.00
D3427	Periradicular surgery without apicoectomy	$470.00
D3430	Retrograde filling - per root	$65.00
D3450	Root amputation, per root	$315.00
D3920	Hemisection (including any root removal), not including root canal therapy	$95.00

D4000-D4999 V. PERIODONTICS

- Includes postoperative evaluations and treatment under a local anesthetic.

Code	Description	Copayment
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$150.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$280.00
D4249	Clinical crown lengthening - hard tissue	$280.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$650.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$520.00
D4270	Pedicle soft tissue graft procedure	$290.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$95.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$300.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$300.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$85.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$64.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$80.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$70.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be*

provided at the Contract Dentist's facility where the denture was originally delivered.
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

Code	Description	Fee
D5110	Complete denture - maxillary	$495.00
D5120	Complete denture - mandibular	$495.00
D5130	Immediate denture - maxillary	$550.00
D5140	Immediate denture - mandibular	$550.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$400.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$400.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$565.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$565.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$700.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$700.00
D5410	Adjust complete denture - maxillary	$24.00
D5411	Adjust complete denture - mandibular	$24.00
D5421	Adjust partial denture - maxillary	$24.00
D5422	Adjust partial denture - mandibular	$24.00
D5510	Repair broken complete denture base	$55.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40.00
D5610	Repair resin denture base	$60.00
D5620	Repair cast framework	$60.00
D5630	Repair or replace broken clasp	$75.00
D5640	Replace broken teeth - per tooth	$45.00
D5650	Add tooth to existing partial denture	$60.00
D5660	Add clasp to existing partial denture	$75.00
D5710	Rebase complete maxillary denture	$180.00
D5711	Rebase complete mandibular denture	$180.00
D5720	Rebase maxillary partial denture	$180.00
D5721	Rebase mandibular partial denture	$180.00
D5730	Reline complete maxillary denture (chairside)	$75.00
D5731	Reline complete mandibular denture (chairside)	$75.00
D5740	Reline maxillary partial denture (chairside)	$75.00
D5741	Reline mandibular partial denture (chairside)	$75.00

Code	Description	Fee
D5750	Reline complete maxillary denture (laboratory)	$150.00
D5751	Reline complete mandibular denture (laboratory)	$150.00
D5760	Reline maxillary partial denture (laboratory)	$150.00
D5761	Reline mandibular partial denture (laboratory)	$150.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$175.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$175.00
D5850	Tissue conditioning, maxillary	$40.00
D5851	Tissue conditioning, mandibular	$40.00

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])

- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

Code	Description	Fee
D6210	Pontic - cast high noble metal	$425.00
D6211	Pontic - cast predominantly base metal	$325.00
D6212	Pontic - cast noble metal	$425.00
D6240	Pontic - porcelain fused to high noble metal [2, 3]	$425.00
D6241	Pontic - porcelain fused to predominantly base metal [2]	$325.00
D6242	Pontic - porcelain fused to noble metal [2]	$425.00
D6245	Pontic - porcelain/ceramic [2, 3]	$495.00
D6250	Pontic - resin with high noble metal [2]	$425.00
D6251	Pontic - resin with predominantly base metal [2]	$325.00
D6252	Pontic - resin with noble metal [2]	$425.00
D6600	Inlay - porcelain/ceramic, two surfaces [2]	$385.00
D6601	Inlay - porcelain/ceramic, three or more surfaces [2]	$405.00
D6602	Inlay - cast high noble metal, two surfaces	$370.00
D6603	Inlay - cast high noble metal, three or more surfaces	$380.00
D6604	Inlay - cast predominantly base metal, two surfaces	$270.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	$280.00
D6606	Inlay - cast noble metal, two surfaces	$370.00
D6607	Inlay - cast noble metal, three or more surfaces	$380.00
D6608	Onlay - porcelain/ceramic, two surfaces [2]	$395.00
D6609	Onlay - porcelain/ceramic, three or more surfaces [2]	$415.00
D6610	Onlay - cast high noble metal, two surfaces	$370.00
D6611	Onlay - cast high noble metal, three or more surfaces	$390.00
D6612	Onlay - cast predominantly base metal, two surfaces	$270.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	$290.00
D6614	Onlay - cast noble metal, two surfaces	$370.00

Code	Description	Fee
D6615	Onlay - cast noble metal, three or more surfaces	$390.00
D6720	Crown - resin with high noble metal [2]	$425.00
D6721	Crown - resin with predominantly base metal [2]	$325.00
D6722	Crown - resin with noble metal [2]	$425.00
D6740	Crown - porcelain/ceramic [2, 3]	$495.00
D6750	Crown - porcelain fused to high noble metal [2, 3, 4]	$425.00
D6751	Crown - porcelain fused to predominantly base metal [2, 4]	$325.00
D6752	Crown - porcelain fused to noble metal [2, 4]	$425.00
D6780	Crown - ¾ cast high noble metal	$425.00
D6781	Crown - ¾ cast predominantly base metal	$325.00
D6782	Crown - ¾ cast noble metal	$425.00
D6783	Crown - ¾ porcelain/ceramic [2, 3]	$495.00
D6790	Crown - full cast high noble metal	$425.00
D6791	Crown - full cast predominantly base metal	$325.00
D6792	Crown - full cast noble metal	$425.00
D6930	Recement fixed partial denture	$30.00
D6940	Stress breaker	$50.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$75.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

Code	Description	Fee
D7111	Extraction, coronal remnants - deciduous tooth	$35.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$45.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$70.00
D7220	Removal of impacted tooth - soft tissue	$100.00
D7230	Removal of impacted tooth - partially bony	$190.00
D7240	Removal of impacted tooth - completely bony	$210.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$230.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$75.00
D7251	Coronectomy - intentional partial tooth removal	$230.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$100.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$150.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$150.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$200.00

Code	Description	Copayment
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$200.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$150.00
D7472	Removal of torus palatinus	$150.00
D7473	Removal of torus mandibularis	$150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$35.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$160.00

D8000-D8999 XI. ORTHODONTICS

- *The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*
- *The Retention Copayment includes removal of appliances, construction and placement of removable retainers, and up to 24 months of adjustments and/or office visits.*

Code	Description	Copayment
D8010	Limited orthodontic treatment of the primary dentition	$1,400.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,400.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,400.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,600.00
D8050	Interceptive orthodontic treatment of the primary dentition	$1,650.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$1,650.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$2,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$2,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,900.00
D8660	Pre-orthodontic treatment visit [5]	No Cost
D8670	Periodic orthodontic treatment visit (as part of contract)	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$250.00
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$200.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

Code	Description	Copayment
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$35.00
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
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$70.00

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$10.00
D9440	Office visit - after regularly scheduled hours	$40.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9951	Occlusal adjustment, limited	$40.00
D9952	Occlusal adjustment, complete	$90.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$15.00

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.

FOOTNOTES

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

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

[3] *Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

[4] *For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of $75.00.*

[5] *In the event orthodontic treatment is not required or is declined by the Enrollee, a fee of $85.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. Fillings (amalgams and composites) are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
3. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling.
4. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec), the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if you have questions regarding the additional fee or name brand services.
5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
      - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
6. Coverage for the placement of a fixed partial denture (bridge) requires that:
   a. No cantilevered posterior pontic (prosthetic tooth) be included; **and**
      - The sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; **or**
      - The new bridge would replace an existing, non-functional bridge; **or**
      - Each abutment tooth to be crowned meets Limitation #3.

7. Benefits for retained primary teeth are limited to services applicable to a primary tooth.
8. Excision of the frenum is a benefit only when it causes limited mobility of the tongue, a large diastema between teeth or it interferes with a prosthetic appliance.
9. 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. The Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.
10. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
11. 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.
12. 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.
13. 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.
14. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. 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, full or partial dentures for which an impression has been taken and orthodontics.
6. Prescription and over-the-counter drugs.
7. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
8. Dental services received from any dental facility other than the assigned Contract Dentist, or a preauthorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist), except for Emergency Services as described in the Disclosure Form/Contract.
9. Consultations or other diagnostic services for non-covered benefits.
10. Duplication of x-rays.
11. Implant supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
13. Services solely for cosmetic purposes, with the exception of procedure D9975, (External bleaching for home application, per arch) or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

14. Procedures, appliances or restorations if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures D9951 and D9952 as shown on Schedule A.
15. 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 affect any other Benefits.
16. 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.
17. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
18. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
19. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
20. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue 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.
21. Myofunctional and parafunctional appliances and/or therapies.
22. Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
23. Pre-, mid- and post-treatment records for orthodontia including cephalometric x-rays, tracings, photographs and study models.
24. Changes in orthodontic treatment necessitated by accident of any kind.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a

potential organ donor. An organ procurement organization will become involved to coordinate the activities.

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

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

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-422-4234. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-422-4234. También puede recibir este documento en español o chino.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。 如需免費協助，請電 Delta Dental 1-800-422-4234 您也能取得這份文件的西班牙文或中文譯本。

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.