Welcome to DeltaCare USA

DeltaCare USA (administered by Delta Dental of California) 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.

Quality
- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, 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

Cost savings
- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $50 per emergency
- No annual or lifetime dollar maximum
"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, including your spouse or registered domestic partner and unmarried children (which includes natural, step, legally adopted and/or foster children to the age of 23). 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 including 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 $50 under the Basic Plan 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?
Under the Basic Plan, you and your eligible dependents will receive care from the same contract facility. This facility will take care of all dental care needs for you and your family.

Can I change my contract dentist?
You may change contract dentists by notifying us either by phone or in writing, or by visiting our web site (www.deltadentalca.org/csui). If you contact us by the 21st of the month, the change will become effective the first of the following month.
How do I know DeltaCare USA dentists provide quality care?
DeltaCare USA dentists are reviewed for quality, availability and safety before joining the panel. Delta Dental maintains quality standards by visiting each contract dental facility every three months.

How are DeltaCare USA dentists compensated?
A contract dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of enrollees assigned to the dentist), and by enrollees through required copayments for treatment received. A contract specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable copayment paid by the enrollee. In no event does Delta Dental pay a contract dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment. You may obtain further information concerning compensation by calling Delta Dental's Customer Service department at 800-422-4234.

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).

I have treatment in progress. What should I do?
You must continue treatment through the provider who started your work. The provider is required to complete the treatment at the original agreed upon fee. As much as possible, please plan to start and conclude treatment under your current provider prior to your DeltaCare USA effective date. All future treatment must be provided by your assigned DeltaCare USA provider.

Any expense related to the completion of work in progress is not a benefit under the DeltaCare USA program.

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 have worked in dental facilities and 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 and governing administrative policies of the program. Please refer to Schedules B, C and F for further clarification of benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

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

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>ENROLLEE PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100-D0999</td>
<td><strong>I. DIAGNOSTIC</strong></td>
<td></td>
</tr>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient ........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused ...........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient .....................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report ...........</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient .............</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral radiographs - complete series (including bitewings) - limited to 1 series every 24 months</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first film .......................................................</td>
<td>No Cost</td>
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<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional film ...........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film .........................................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - first film ................................................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0260</td>
<td>Extraoral - each additional film ................................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing radiograph - single film ............................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings radiographs - two films ................................................................</td>
<td>No Cost</td>
</tr>
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<td>D0273</td>
<td>Bitewings radiographs - three films .......................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings radiographs - four films - limited to 1 series every 6 months ......</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film ...........................................................................................</td>
<td>No Cost</td>
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<tr>
<td>D0460</td>
<td>Pulp vitality tests .....................................................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0999</td>
<td>Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1000-D1999</td>
<td><strong>II. PREVENTIVE</strong></td>
<td></td>
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<tr>
<td>D1110</td>
<td>Prophylaxis cleaning - adult - 2 per 12 month period ................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis cleaning - child - 2 per 12 month period ................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (prophylaxis not included) - child - to age 19; 1 per 6 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - child to age 19; 1 per 6 month period</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions ..........................................................................</td>
<td>No Cost</td>
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<tr>
<td>D1351</td>
<td>Sealant - per tooth - limited to permanent molars to age 14 ....................</td>
<td>$5.00</td>
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<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral ......................................................</td>
<td>$10.00</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral ........................................................</td>
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<td>D1520</td>
<td>Space maintainer - removable - unilateral ...............................................</td>
<td>$10.00</td>
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<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral ..................................................</td>
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<tr>
<td>D1550</td>
<td>Re-cementation of space maintainer ...........................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer ................................................................</td>
<td>No Cost</td>
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<tr>
<td>D2000-D2999</td>
<td><strong>III. RESTORATIVE</strong></td>
<td></td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent ...........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent ...........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent ..........................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent ................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior ..........................................</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
### Description of Benefits and Copayments

**D2331**  Resin-based composite - two surfaces, anterior ................................................................. No Cost  
**D2332**  Resin-based composite - three surfaces, anterior ............................................................... No Cost  
**D2335**  Resin-based composite - four or more surfaces or involving incisal angle (anterior) .................... No Cost  
**D2390**  Resin-based composite crown, anterior .................................................................................. No Cost  
**D2510**  Inlay - metallic - one surface ..................................................................................................... $50.00  
**D2520**  Inlay - metallic - two surfaces ..................................................................................................... $50.00  
**D2530**  Inlay - metallic - three or more surfaces ..................................................................................... $50.00  
**D2543**  Onlay - metallic - three surfaces .................................................................................................. $50.00  
**D2712**  Crown - resin-based composite (indirect) .................................................................................. $35.00  
**D2720**  Crown - resin with high noble metal .......................................................................................... $50.00  
**D2721**  Crown - resin with predominantly base metal .......................................................................... $50.00  
**D2722**  Crown - resin with noble metal .................................................................................................. $50.00  
**D2740**  Crown - porcelain/ceramic substrate ......................................................................................... $50.00  
**D2750**  Crown - porcelain fused to high noble metal ............................................................................ $50.00  
**D2751**  Crown - porcelain fused to predominantly base metal ............................................................ $50.00  
**D2752**  Crown - porcelain fused to noble metal ..................................................................................... $50.00  
**D2780**  Crown - ¾ cast high noble metal ............................................................................................. $50.00  
**D2781**  Crown - ¾ cast predominantly base metal ................................................................................. $50.00  
**D2782**  Crown - ¾ cast noble metal ....................................................................................................... $50.00  
**D2790**  Crown - full cast high noble metal ........................................................................................... $50.00  
**D2791**  Crown - full cast predominantly base metal .............................................................................. $50.00  
**D2792**  Crown - full cast noble metal .................................................................................................... $50.00  
**D2794**  Crown - titanium ....................................................................................................................... $50.00  
**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  
**D2930**  Prefabricated stainless steel crown - primary tooth ................................................................ No Cost  
**D2931**  Prefabricated stainless steel crown - permanent tooth ............................................................... No Cost  
**D2940**  Sedative filling ............................................................................................................................ No Cost  
**D2950**  Core build-up, including any pins ............................................................................................. No Cost  
**D2951**  Pin retention - per tooth, in addition to restoration ..................................................................... No Cost  
**D2952**  Post and core in addition to crown, indirectly fabricated - includes canal preparation ................. No Cost  
**D2953**  Each additional indirectly fabricated post - same tooth - includes canal preparation ................. No Cost  
**D2954**  Prefabricated post and core in addition to crown - base metal post; includes canal preparation .... No Cost  
**D2957**  Each additional prefabricated post - same tooth - base metal post; includes canal preparation ...... No Cost  
**D2970**  Temporary crown (fractured tooth) - palliative treatment only .................................................. No Cost  

### 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  
**D3310**  Root canal - anterior (excluding final restoration) ...................................................................... $20.00  
**D3320**  Root canal - bicuspid (excluding final restoration) ..................................................................... $40.00  
**D3330**  Root canal - molar (excluding final restoration) .......................................................................... $60.00  
**D3346**  Retreatment of previous root canal therapy - anterior ................................................................ $20.00  
**D3347**  Retreatment of previous root canal therapy - bicuspid ................................................................. $40.00  
**D3348**  Retreatment of previous root canal therapy - molar ..................................................................... $60.00  
**D3351**  Apexification/recallification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (to age 14) ........................................................................................................................................ No Cost  
**D3352**  Apexification/recallification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (to age 14) ............................................................................... No Cost  
**D3353**  Apexification/recallification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) (to age 14) ........................................................................ No Cost  
**D3410**  Apicoectomy/periradicular surgery - anterior ............................................................................. No Cost  
**D3421**  Apicoectomy/periradicular surgery - bicuspid (first root) ............................................................. No Cost  
**D3425**  Apicoectomy/periradicular surgery - molar (first root) .................................................................... No Cost
### Description of Benefits and Copayments

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3426</td>
<td>Apicoectomy/peridicular surgery (each additional root)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling - per root</td>
<td>No Cost</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation, per root - <em>not covered in conjunction with a hemisection</em></td>
<td>No Cost</td>
</tr>
</tbody>
</table>

**D4000-D4999  V. PERIODONTICS**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$20.00</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>No Cost</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$80.00</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$80.00</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$80.00</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$80.00</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing - four or more teeth per quadrant - <em>limited to 4 quadrants during any 12 consecutive months</em></td>
<td>$10.00</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing - one to three teeth per quadrant - <em>limited to 4 quadrants during any 12 consecutive months</em></td>
<td>$10.00</td>
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<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis - <em>limited to 1 treatment in any 12 consecutive months</em></td>
<td>$10.00</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance - <em>limited to 2 treatments each 12 month period</em></td>
<td>$8.00</td>
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</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
<td>$60.00</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
<td>$60.00</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
<td>$60.00</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
<td>$60.00</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$70.00</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$70.00</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$70.00</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$70.00</td>
</tr>
<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>No Cost</td>
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<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>No Cost</td>
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<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>$5.00</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
<td>$5.00</td>
</tr>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>$15.00</td>
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<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>$15.00</td>
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<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>$15.00</td>
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<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>$15.00</td>
</tr>
<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary) - <em>limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing</em></td>
<td>No Cost</td>
</tr>
</tbody>
</table>

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4. Interim partial denture (maxillary) - *limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing* - No Cost
Plan CAM34

Description of Benefits and Copayments

D5821 Interim partial denture (mandibular) - limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing ................................................................. No Cost
D5850 Tissue conditioning, maxillary ............................................................................................................... No Cost
D5851 Tissue conditioning, mandibular ............................................................................................................. No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

D6210 Pontic - cast high noble metal .......................................................... $50.00
D6211 Pontic - cast predominantly base metal ........................................... $50.00
D6212 Pontic - cast noble metal ................................................................... $50.00
D6240 Pontic - porcelain fused to high noble metal .................................. $50.00
D6241 Pontic - porcelain fused to predominantly base metal ................... $50.00
D6242 Pontic - porcelain fused to noble metal ............................................ $50.00
D6250 Pontic - resin with high noble metal ............................................... $50.00
D6251 Pontic - resin with predominantly base metal ............................... $50.00
D6252 Pontic - resin with noble metal ...................................................... $50.00
D6602 Inlay - cast high noble metal, two surfaces ....................................... $50.00
D6603 Inlay - cast high noble metal, three or more surfaces .................... $50.00
D6604 Inlay - cast predominantly base metal, two surfaces .................... $50.00
D6605 Inlay - cast predominantly base metal, three or more surfaces ........ $50.00
D6606 Inlay - cast noble metal, two surfaces ........................................... $50.00
D6607 Inlay - cast noble metal, three or more surfaces ........................... $50.00
D6611 Onlay - cast high noble metal, three or more surfaces .................... $50.00
D6613 Onlay - cast predominantly base metal, three or more surfaces ...... $50.00
D6615 Onlay - cast noble metal, three or more surfaces ........................... $50.00
D6720 Crown - resin with high noble metal .............................................. $50.00
D6721 Crown - resin with predominantly base metal ............................... $50.00
D6722 Crown - resin with noble metal ..................................................... $50.00
D6750 Crown - porcelain fused to high noble metal ................................. $50.00
D6751 Crown - porcelain fused to predominantly base metal .................. $50.00
D6752 Crown - porcelain fused to noble metal ........................................... $50.00
D6780 Crown - ¾ cast high noble metal ................................................... $50.00
D6781 Crown - ¾ cast predominantly base metal ...................................... $50.00
D6782 Crown - ¾ cast noble metal ............................................................ $50.00
D6790 Crown - full cast high noble metal ................................................. $50.00
D6791 Crown - full cast predominantly base metal ................................... $50.00
D6792 Crown - full cast noble metal ......................................................... $50.00
D6930 Recement fixed partial denture ....................................................... No Cost
D6940 Stress breaker .................................................................................. No Cost
D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated - includes canal preparation .................................................. No Cost
D6972 Prefabricated post and core in addition to fixed partial denture retainer - base metal post; includes canal preparation .................................................. No Cost
D6973 Core buildup for retainer, including any pins ................................... No Cost
D6976 Each additional indirectly fabricated post - same tooth - includes canal preparation ................................................................. No Cost
D6977 Each additional prefabricated post - same tooth - base metal post; includes canal preparation ................................................................. No Cost

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 elevation of mucoperiosteal flap and removal of bone and/or section of tooth ................................................................. No Cost
D7220 Removal of impacted tooth - soft tissue ........................................ No Cost
D7230 Removal of impacted tooth - partially bony .................................... $15.00
D7240 Removal of impacted tooth - completely bony ................................ $25.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications $25.00
D7250 Surgical removal of residual tooth roots (cutting procedure) .......... No Cost
D7285 Biopsy of oral tissue - hard (bone, tooth) - does not include pathology laboratory procedures No Cost
D7286 Biopsy of oral tissue - soft - does not include pathology laboratory procedures No Cost
Plan CAM34

Description of Benefits and Copayments

D7310  Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...........................................  No Cost
D7311  Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...........................................  No Cost
D7320  Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...........................................  No Cost
D7321  Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...........................................  No Cost
D7450  Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.................................................................  No Cost
D7471  Removal of lateral exostosis (maxilla or mandible) .................................................................  No Cost
D7510  Incision and drainage of abscess - intraoral soft tissue .................................................................................................  No Cost
D7960  Frenulectomy (frenectomy or frenotomy) - separate procedure .................................................................................................  No Cost

D8000-D8999  XI. ORTHODONTICS

D8070  Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19  ........................................... $1,400.00
D8080  Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19  ........................................... $1,400.00
D8090  Comprehensive orthodontic treatment of the adult dentition - adults, including dependent adult children to age 23  ........................................... $1,400.00
D8660  Pre-orthodontic treatment visit - not to be charged with any other consultation procedure(s) ...........................................  No Cost
D8680  Orthodontic retention (removal of appliances, construction and placement of retainers) ...........................................  No Cost
D8999  Unspecified orthodontic procedure, by report - includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding ........................................... $350.00

D9000-D9999  XII. ADJUNCTIVE GENERAL SERVICES

D9110  Palliative (emergency) treatment of dental pain - minor procedure........................................................................  No Cost
D9211  Regional block anesthesia ............................................................................................................................................  No Cost
D9212  Trigeminal division block anesthesia ............................................................................................................................................  No Cost
D9215  Local anesthesia ............................................................................................................................................  No Cost
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 ...........................................  No Cost
D9440  Office visit - after regularly scheduled hours ............................................................................................................................................  No Cost
D9951  Occlusal adjustment, limited ............................................................................................................................................  No Cost
D9952  Occlusal adjustment, complete ............................................................................................................................................  No Cost
D9999  Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice ........................................... $5.00

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

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

FOOTNOTES

1 Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns (including titanium crowns), bridges, indirectly fabricated posts and cores, inlays and onlays.

2 Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $75.00.

3 Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 24 months of active treatment, an additional monthly fee of $25.00 applies.

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

5 Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $25.00 applies.
Limitations and Exclusions of Benefits

SCHEDULE B

Limitations of Benefits

1. Prophylaxis is limited to two treatments in a 12 month period (includes periodontal maintenance).
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.
5. Denture relines are limited to one per denture during any 12 consecutive months.
6. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
8. Bitewing x-rays are limited to not more than one series of four films in any six month period.
9. Full mouth x-rays are limited to one set every 24 consecutive months.
10. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
11. Accidental injury, except as noted in the Accident Injury Rider. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
8. Any service that is not specifically listed as a covered expense.
9. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress.
10. Congenital malformations (e.g. congenitally missing teeth, supernumerary).
11. Cysts and malignancies, except as noted under Schedule A, Description of Benefits and Copayments.
12. Dispensing of drugs not normally supplied in a dental facility.
13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by Delta Dental or as cited under Emergency Services.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
17. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

Exclusions of Benefits

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
4. Dental services performed in a hospital and related hospital fees.
5. Treatment of fractures and dislocations.
Orthodontic Limitations

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

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

8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrogna-thia.
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to a per office visit charge of $25.00.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Transfer after banding has been initiated.
15. Lingually placed direct banded appliances, brackets and arch wires (invisible braces).
Limitations and Exclusions of Benefits

SCHEDULE C

Governing Administrative Policies

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

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

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

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

A. PARTIAL DENTURES

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

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

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

B. COMPLETE DENTURES

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

C. FILLINGS AND CROWNS

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

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

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

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

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

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

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

D. FIXED BRIDGES

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent
Limitations and Exclusions of Benefits

anterior tooth in a person 16 years old or older. Such treatment will be covered if the Enrollee's oral health and general dental condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

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

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

Fixed bridges are not a benefit for Enrollees under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist’s “filed fees” for the covered benefit and optional treatment, plus any copayment for the covered benefit.

E. RECONSTRUCTION

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

F. SPECIALIZED TECHNIQUES

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

G. PREVENTIVE CONTROL PROGRAMS

Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special tooth brush, etc., is considered as optional treatment. If performed, the Enrollee is responsible for the cost.

H. STAYPLATES

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

I. FRENECTOMY

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

J. PEDODONTIA

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

K. CORRECTION OF OCCLUSION

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

L. TREATMENT PLANNING

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

1. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee’s overall oral health.
Limitations and Exclusions of Benefits

2. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.

3. Priority is then given to replacement of missing teeth not causing a gross lack of function.

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

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

Accident Injury Benefit

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

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

I. DEFINITIONS

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

A. "Attending Dentist's Statement" means the standard form used to file a claim.

B. "Dental Accident Benefits" means those dental services which are provided under the terms of this Rider for conditions caused directly and independently of all other causes, by external, violent and accidental means.

C. "Fee Actually Charged" means the "filed fee" for a particular dental service or procedure which a Contract Dentist reports to Delta Dental on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, rebated or which the Dentist does not in good faith attempt to collect.

D. "Prevailing Fee" means the fee for a Single Procedure which satisfies the majority of Dentists in California, as determined by Delta Dental.

E. "Single Procedure" means a dental procedure listed on a separate line in Schedule A and in paragraph II of this Rider, Schedule F.

F. The term "filed fee" as used in this Rider shall have the following meaning:

"Filed Fee" means the Contract Dentist's fees on file with Delta Dental.

II. DENTAL ACCIDENT BENEFITS

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

A. Intra-oral grafting

B. Reimplantation

C. Splinting

D. Stayplate

III. MAXIMUM

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

IV. LIMITATION

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

V. EXCLUSIONS

The following services are not Dental Accident Benefits:

A. Services for injuries or conditions which are benefits provided to the eligible Enrollee through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.

B. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration
of the teeth), and anodontia (congenitally missing teeth).

C. Services for restoring or stabilizing tooth structure lost from wear, or for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion. Such services include but are not limited to: equilibration and periodontal splinting.

D. Prosthodontic services or any Single Procedure started prior to the date the Enrollee became eligible for such services under this Contract.

E. Prescribed drugs, pre-medication or analgesia.

F. Experimental procedures.

G. Prophylaxis.

H. All hospital costs and any additional fees charged by the Dentist for hospital treatment.

I. Charges for general anesthesia.

J. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

K. Implants (materials implanted into or on bone or soft tissue), the removal of implants or procedures related to the placement or removal of implants.

L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

M. Replacement of existing restorations due to carious lesions.

N. Orthodontic services (treatment of malalignment of teeth and/or jaws).
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 the Customer Service department at 800-422-4234.

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

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

Provided and Administered by:

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www.deltadentalca.org/csu

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