



Benefit highlights

DeltaCare® USA

Provided by
DELTA DENTAL OF CALIFORNIA
San Francisco Health Service System
January 1, 2027

DeltaCare USA¹ offers you a straightforward and affordable plan that provides easy to access dental care from a trusted in-network dentist you choose.² You'll know what procedures are covered and how much each costs. No surprises.

Comprehensive coverage

- Coverage for 350+ procedures
- Regular preventive care with low or no copayments to help catch issues before they become more serious
- Specialist services for oral surgery, endodontics, orthodontics, periodontics and pediatric dentistry

Budget-friendly

- No deductibles or maximums³ for covered services⁴
- Out-of-pocket costs listed in your Evidence of Coverage booklet, available in your online account



- All-inclusive copayments (no material or lab fees)
- Cleanings and exams covered with low or no copayments

Large network of quality dentists

Delta Dental is a leading national carrier that offers a large network of high-quality and rigorously vetted dentists. DeltaCare USA dentists are credentialed and meet Delta Dental's strict standards of care. When specialty dental care is needed, your general dentist (or pediatric dentist for children through age 13) will refer you to a trusted specialist in the network.

Convenient services

We make it easy for you — your DeltaCare USA network dentist will take care of all the paperwork, and no ID card is required to receive treatment.⁵

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

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

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.

² Verify your selected DeltaCare USA general dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

⁴ State-specific exceptions may apply.

⁵ You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment.

deltadentalins.com/ccsf

What you need to know in advance, or about your DeltaCare[®] USA plan

How DeltaCare USA works

- **You must visit** a DeltaCare USA general dentist to use your plan.¹
 - Your general dentist will coordinate and refer you to specialists for care, if needed.
 - Dependent children may obtain covered care from an in-network pediatric dentist without referral from a general dentist through age 13.
- **You may select** an in-network general dentist, or a general dentist can be assigned at first visit if you haven't selected a dentist yet.²
- **You can select** or change dentists anytime online or by phone.
- **Pay predefined, all-inclusive copayments** — with no hidden fees (no material or lab fees) at the time of service.
- **No deductibles, maximums or waiting periods** for covered services. No claims to submit — no hassle!
- **Clear out-of-pocket costs** shown in your Evidence of Coverage located in your online account

What your plan covers

You're covered for hundreds of procedures with no annual limit on the amount your plan pays.

- Comprehensive coverage for 350+ procedures that prioritizes preventive care
- Cleanings and exams covered with low or no copayments
- Orthodontics coverage for adults and children, including clear aligners
- Extensive care including crowns, dentures, root canals, oral surgery and more

Getting started

To enroll in a DeltaCare USA plan, simply complete the enrollment process as directed by the San Francisco Health Service System. Select a California DeltaCare USA dentist or check to see if your California preferred general dentist is in-network.

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

- **The name, address and phone number of your selected general dentist or instructions on how to select one.** Simply call the dental facility to make an appointment. Important note: In order to receive benefits under your plan, you must visit your general dentist facility. You can visit any DeltaCare USA general dentist at your selected dental facility as long as they are in the California DeltaCare USA network.
- **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
- **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

Visit deltadentalins.com/ccsf to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your general dentist and more.

- **Access your plan benefits.** Your Evidence of Coverage can be located in your online account under the benefit details section. You can view or download a copy of the document for your records. This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan
- **Locate an electronic ID card.** This card is for your records only — you do not need to present it in order to receive treatment. You can view, print or email a copy of your electronic ID card.
- **General dentist.** If selected, you can find the name, address and phone number of your assigned general dentist. You can use our search tool to find, select or change your DeltaCare USA general dentist.

¹ In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.

² If you have not yet been assigned to a DeltaCare USA general dentist, you can do so by visiting any DeltaCare USA general dentist that is accepting new patients. When your selected dentist files a qualifying claim, you will be added to their roster and they will become your assigned DeltaCare USA general dentist. Once assigned, you must visit this dentist for future visits to receive benefits. Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist.

To get care, call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit a DeltaCare USA dentist. You can visit any DeltaCare USA general dentist at your selected dental facility as long as they are in the DeltaCare USA network. There is no coverage for out-of-network care.

General plan information

You and your eligible dependents have emergency dental service coverage for out-of-area emergencies.¹ Your out-of-area emergency benefit (typically limited to \$100 per person) is for services to relieve pain until you can return to see your general dentist.² Standard plan limitations, exclusions and copayments may apply.

There are no exclusions for most pre-existing conditions, except work in progress.² Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

Glossary

Here are some common terms that will help you understand your plan:

Authorization: The process by which Delta Dental determines whether a procedure or treatment is a referable benefit under your plan.

Copayment, or copay amount: The fixed dollar amount a member is responsible for when receiving treatment.

DeltaCare USA dentist: A dentist who is a member of the DeltaCare USA network. These dentists have contracted with Delta Dental and agreed to accept negotiated fees for the services provided to DeltaCare USA members.

Diagnostic and preventive services: A category of dental services that includes benefits for oral evaluations, routine cleanings, x-rays and fluoride treatments. There are low or no copayments for these services to encourage you to seek regular care and prevent problems from developing.

Effective date: The date your dental plan becomes active. Also, the date a member becomes eligible for benefits.

Evidence of Coverage (EOC): A guide that details your specific dental plan benefits, covered services, exclusions, limitations, deductibles and copayments. Also known as Certificate of Coverage.

Limitations and Exclusions: Limitations are usually related to a specific time or frequency — for example, a plan may cover only two cleanings in a 12-month period or one cleaning every six months. Exclusions are services not covered by a plan.

(Dental) Referral: Directing a patient to a dental specialist by a general dentist.⁴

Specialist services: Services performed by a dental specialist, such as oral surgery, endodontics, periodontics or pediatric dentistry. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.⁵



For more help with understanding dental terms, visit
www1.deltadentalins.com/members/glossary.html



¹ State-specific minimum distance requirements may apply.

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

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

⁴ Dependent children covered under a DeltaCare USA plan have the option to seek dental care from a pediatric dentist through the age of 13, whether or not the child has an assigned general dentist. Referrals to visit a pediatric specialist are not required. If the pediatric dentist determines that additional specialty care is needed, they may refer pediatric patients directly to other specialists, such as an orthodontist. At age 14, covered dependent children must obtain care from their assigned DeltaCare USA general dentist.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Schedule B - Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your 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 Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2027 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>YOU PAY</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0460	Pulp vitality tests	No Cost
D0461	Testing for cracked tooth	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost

D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999**II. PREVENTIVE**

D1110	Prophylaxis <i>cleaning</i> - adult - 1 per 6 month period	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - 1 per 6 month period	No Cost
D1206	Application of medicament - topical fluoride varnish; full mouth - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Application of medicament - topical fluoride - excluding varnish; full mouth - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1354	Application of caries arresting medicament without surgical intervention - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	No Cost

D2000-D2999**III. RESTORATIVE**

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2390	Resin-based composite crown - direct	No Cost
D2391	Resin-based composite - one surface, posterior ^{1, 11}	Optional
D2392	Resin-based composite - two surfaces, posterior ^{1, 11}	Optional
D2393	Resin-based composite - three surfaces, posterior ^{1, 11}	Optional
D2394	Resin-based composite - four or more surfaces, posterior ^{1, 11}	Optional
D2510	Inlay - metallic - one surface ^{2, 9}	No Cost
D2520	Inlay - metallic - two surfaces ^{2, 9}	No Cost
D2530	Inlay - metallic - three or more surfaces ^{2, 9}	No Cost
D2542	Onlay - metallic - two surfaces ^{2, 9}	No Cost
D2543	Onlay - metallic - three surfaces ^{2, 9}	No Cost
D2544	Onlay - metallic - four or more surfaces ^{2, 9}	No Cost
D2610	Inlay - porcelain/ceramic - one surface ^{1, 9}	Optional
D2620	Inlay - porcelain/ceramic - two surfaces ^{1, 9}	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces ^{1, 9}	Optional
D2642	Onlay - porcelain/ceramic - two surfaces ^{1, 9}	Optional
D2643	Onlay - porcelain/ceramic - three surfaces ^{1, 9}	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces ^{1, 9}	Optional

D2650	Inlay - resin-based composite - one surface ^{1, 9}	Optional
D2651	Inlay - resin-based composite - two surfaces ^{1, 9}	Optional
D2652	Inlay - resin-based composite - three or more surfaces ^{1, 9}	Optional
D2662	Onlay - resin-based composite - two surfaces ^{1, 9}	Optional
D2663	Onlay - resin-based composite - three surfaces ^{1, 9}	Optional
D2664	Onlay - resin-based composite - four or more surfaces ^{1, 9}	Optional
D2710	Crown - resin-based composite (indirect) ^{3, 9}	No Cost
D2712	Crown - 3/4 resin-based composite (indirect) ^{3, 9}	No Cost
D2720	Crown - resin with high noble metal ^{2, 3, 9}	No Cost
D2721	Crown - resin with predominantly base metal ^{3, 9}	No Cost
D2722	Crown - resin with noble metal ^{3, 9}	No Cost
D2740	Crown - porcelain/ceramic ^{3, 9}	No Cost
D2750	Crown - porcelain fused to high noble metal ^{2, 3, 9}	No Cost
D2751	Crown - porcelain fused to predominantly base metal ^{3, 9}	No Cost
D2752	Crown - porcelain fused to noble metal ^{3, 9}	No Cost
D2753	Crown - porcelain fused to titanium and titanium alloys	No Cost
D2780	Crown - 3/4 cast high noble metal ^{2, 9}	No Cost
D2781	Crown - 3/4 cast predominantly base metal ⁹	No Cost
D2782	Crown - 3/4 cast noble metal ⁹	No Cost
D2790	Crown - full cast high noble metal ^{2, 9}	No Cost
D2791	Crown - full cast predominantly base metal ⁹	No Cost
D2792	Crown - full cast noble metal ⁹	No Cost
D2794	Crown - titanium and titanium alloys ^{2, 9}	No Cost
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Placement of interim direct restoration	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ²	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2976	Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i>	No Cost
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to 1 per 24 months</i>	No Cost

D3000-D3999**IV. ENDODONTICS**

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost

D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) ¹⁰	No Cost
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) ¹⁰	No Cost
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration) ¹⁰	No Cost
D3346	Retreatment of previous root canal therapy - anterior ¹⁰	No Cost
D3347	Retreatment of previous root canal therapy - premolar ¹⁰	No Cost
D3348	Retreatment of previous root canal therapy - molar ¹⁰	No Cost
D3410	Apicoectomy - anterior ¹⁰	No Cost
D3421	Apicoectomy - premolar (first root) ¹⁰	No Cost
D3425	Apicoectomy - molar (first root) ¹⁰	No Cost
D3426	Apicoectomy (each additional root) ¹⁰	No Cost
D3430	Retrograde filling - per root ¹⁰	No Cost
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i> ¹⁰	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary ^{4, 12}	No Cost
D5120	Complete denture - mandibular ^{4, 12}	No Cost
D5130	Immediate denture - maxillary ^{4, 12}	No Cost
D5140	Immediate denture - mandibular ^{4, 12}	No Cost
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) ^{4, 12} ...	No Cost
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) ^{4, 12}	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ^{4, 12}	No Cost

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ^{4, 12}	No Cost
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	No Cost
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	No Cost
D5410	Adjust complete denture - maxillary ⁴	No Cost
D5411	Adjust complete denture - mandibular ⁴	No Cost
D5421	Adjust partial denture - maxillary ⁴	No Cost
D5422	Adjust partial denture - mandibular ⁴	No Cost
D5511	Repair complete denture base, mandibular	No Cost
D5512	Repair complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture - per tooth	No Cost
D5521	Replace all teeth on complete denture - maxillary	No Cost
D5522	Replace all teeth on complete denture - mandibular	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken retentive/clasping materials - per tooth	No Cost
D5640	Replace missing or broken teeth - partial denture - per tooth	No Cost
D5650	Add tooth to existing partial denture - per tooth	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5710	Rebase complete maxillary denture ⁸	No Cost
D5711	Rebase complete mandibular denture ⁸	No Cost
D5720	Rebase maxillary partial denture ⁸	No Cost
D5721	Rebase mandibular partial denture ⁸	No Cost
D5725	Rebase hybrid prosthesis	No Cost
D5730	Reline complete maxillary denture (chairside) ⁸	No Cost
D5731	Reline complete mandibular denture (chairside) ⁸	No Cost
D5740	Reline maxillary partial denture (chairside) ⁸	No Cost
D5741	Reline mandibular partial denture (chairside) ⁸	No Cost
D5750	Reline complete maxillary denture (laboratory) ⁸	No Cost
D5751	Reline complete mandibular denture (laboratory) ⁸	No Cost
D5760	Reline maxillary partial denture (laboratory) ⁸	No Cost
D5761	Reline mandibular partial denture (laboratory) ⁸	No Cost
D5765	Soft liner for complete or partial removable denture - indirect	No Cost
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing</i> ⁴	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing</i> ⁴	No Cost
D5850	Tissue conditioning, maxillary ^{4, 8}	No Cost
D5851	Tissue conditioning, mandibular ^{4, 8}	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 ^{2, 7}	No Cost
D6211	Pontic - cast predominantly base metal ⁷	No Cost

D6212	Pontic - cast noble metal ⁷	No Cost
D6240	Pontic - porcelain fused to high noble metal ^{2, 3, 7}	No Cost
D6241	Pontic - porcelain fused to predominantly base metal ^{3, 7}	No Cost
D6242	Pontic - porcelain fused to noble metal ^{3, 7}	No Cost
D6243	Pontic - porcelain fused to titanium and titanium alloys	No Cost
D6245	Pontic - porcelain/ceramic ^{1, 7}	Optional
D6250	Pontic - resin with high noble metal ^{2, 3, 7}	No Cost
D6251	Pontic - resin with predominantly base metal ^{3, 7}	No Cost
D6252	Pontic - resin with noble metal ^{3, 7}	No Cost
D6600	Retainer inlay - porcelain/ceramic, two surfaces ^{1, 7}	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces ^{1, 7}	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces ^{2, 7}	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces ^{2, 7}	No Cost
D6604	Retainer inlay - cast predominantly base metal, two surfaces ⁷	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces ⁷	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces ⁷	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces ⁷	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces ^{1, 7}	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces ^{1, 7}	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces ^{2, 7}	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces ^{2, 7}	No Cost
D6612	Retainer onlay - cast predominantly base metal, two surfaces ⁷	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces ⁷	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces ⁷	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces ⁷	No Cost
D6720	Retainer crown - resin with high noble metal ^{2, 3, 7}	No Cost
D6721	Retainer crown - resin with predominantly base metal ^{3, 7}	No Cost
D6722	Retainer crown - resin with noble metal ^{3, 7}	No Cost
D6740	Retainer crown - porcelain/ceramic ^{1, 7}	Optional
D6750	Retainer crown - porcelain fused to high noble metal ^{2, 3, 7}	No Cost
D6751	Retainer crown - porcelain fused to predominantly base metal ^{3, 7}	No Cost
D6752	Retainer crown - porcelain fused to noble metal ^{3, 7}	No Cost
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	No Cost
D6780	Retainer crown - 3/4 cast high noble metal ^{2, 7}	No Cost
D6781	Retainer crown - 3/4 cast predominantly base metal ⁷	No Cost
D6782	Retainer crown - 3/4 cast noble metal ⁷	No Cost
D6784	Retainer crown - 3/4 titanium and titanium alloys	No Cost
D6790	Retainer crown - full cast high noble metal ^{2, 7}	No Cost
D6791	Retainer crown - full cast predominantly base metal ⁷	No Cost
D6792	Retainer crown - full cast noble metal ⁷	No Cost
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker ⁷	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999**X. ORAL AND MAXILLOFACIAL SURGERY**

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	No Cost

D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i>	No Cost
D7284	Excisional biopsy of minor salivary glands	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ⁵	\$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ⁵	\$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> ⁵	\$1,800.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i>	\$2,070.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - <i>not to be charged with any other consultation procedure(s)</i> ⁶	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ¹³	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9936	Cleaning and inspection of occlusal guard - per appliance - <i>limited to bruxism (grinding), one D9944, D9945 or D9946 every three years</i>	\$10.00
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to bruxism (grinding), one D9944, D9945 or D9946 every three years</i>	\$100.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to bruxism (grinding), one D9944, D9945 or D9946 every three years</i>	\$100.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to bruxism (grinding), one D9944, D9945 or D9946 every three years</i>	\$100.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00

D9987	Canceled appointment - without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00	\$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review .	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

FOOTNOTES

- ¹ Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions of the Plan. The applicable charge is the difference between the Contract Dentist's "submitted fee" for the Optional procedure and the "submitted fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Submitted fees" means the Contract Dentist's fees on file with Us. Questions regarding the Plan should be directed to Our Customer Service department at 800-422-4234.
- ² Base or noble metal is the benefit. High noble metal (precious), if used, will be charged at the additional maximum cost of \$100.00 per tooth. This charge also applies to a titanium crown. If an indirectly fabricated post and core is made of high noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgraded post and core.
- ³ Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to You of \$150.00.
- ⁴ Includes after delivery adjustments and tissue conditioning, if needed, for the first six (6) months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for three (3) months following installation if You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
- ⁵ Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of \$75.00 applies.
- ⁶ In the event comprehensive orthodontic treatment is not required or is declined by You, a fee of \$25.00 will apply. You are also responsible for any incurred orthodontic diagnostic record fees.
- ⁷ Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.
- ⁸ Limited to 1 per denture during any 12 consecutive months.
- ⁹ Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.
- ¹⁰ A Benefit for permanent teeth only.
- ¹¹ An amalgam is the Benefit.
- ¹² Replacement is subject to a limitation requiring the existing denture to be 5+ years old.
- ¹³ Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$75.00 applies.

Addendum A-1

Accident Injury Benefit

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A*.

We will pay up to 100 percent of the Contract Dentist's "submitted fees," for expenses incurred for an accident injury, less any applicable Copayment up to a Maximum of \$1,600.00 in any 12-month period.

Accident injury Benefits include the following procedure in addition to those listed in *Schedule A*.

CDT-CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B*, in addition to the following:

Maximum

Accident injury Benefits will be provided up to a maximum of \$1,600.00 in any 12- month period.

Limitation

Accident injury Benefits are limited to services provided because of an accident which occurred while You are covered:

- * this Plan, or
- * under another DeltaCare USA Plan, and
- * if the Benefits for the expenses incurred would have been paid if You had remained covered under that plan.

Exclusions

In addition to Schedule B, additional limitations and exclusions apply:

- * Prophylaxis.
- * Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- * Replacement of existing restorations due to decay.
- * Orthodontic services (treatment of malalignment of teeth and/or jaws).
- * Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

SCHEDULE B

Limitations and Exclusions of Benefits

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

1. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered Benefits.
2. If a biopsy is preauthorized by Us for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.
3. Placement of interim direct restoration is included in the fee for all covered Endodontic procedures (D3220-D3950) when done on the same date by the same Dentist/dental office.
4. The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure.

5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the 5 year limitation.
9. Cleaning of a denture is a benefit only when the patient is fully edentulous. If partially edentulous, this service is included in the fee for procedure D1110, D1120, D4346 or D4910.
10. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If You elect to have high noble metal used instead, the maximum additional cost of this material upgrade is \$100.00 per tooth or pontic. For an indirectly fabricated post and core, the Benefit is for base or noble metal. If You elect to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is \$100.00 per tooth.
11. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If You elect to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is \$150.00 per molar.
12. If a porcelain margin is also chosen by You for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is \$75.00.
13. 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. One 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.
14. A direct or indirect pulp cap is a Benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
15. Except for pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a Benefit on a permanent tooth.
16. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
17. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
18. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
19. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
 - a. Fixed partial denture (bridge):
 - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
 - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics **or**
 - Each abutment tooth to be crowned meets any limitations and exclusions.

- b. Removable partial denture:
 - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
 - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
 - 20. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
 - 21. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
 - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
 - The replacement of permanent tooth/teeth for children under 16 years of age.
 - 22. Retained primary teeth shall be covered as primary teeth.
 - 23. Excision of the frenum is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
 - 24. Benefits provided by a pediatric Dentist are limited to children through age 13 less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
 - 25. In cases of accidental injury, Benefits available are described in *Schedule A, Addendum A-1, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, and this Schedule B*.
 - 26. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If You decline non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.
 - 27. A new removable partial, or complete denture includes after delivery adjustments and tissue conditioning, if needed, at no additional cost for the first six months after placement if You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered. Immediate dentures and immediate removable partial dentures include after delivery adjustments and tissue conditioning at no additional cost for the first three (3) months after placement.
 - 28. An optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions. The applicable charge is the difference between the Contract Dentist's submitted fee for the optional procedure and the submitted fee for the covered procedure, plus any applicable Copayment for the covered procedure.
- "Submitted fees" means the Contract Dentist's fees on file with Us. Questions regarding these fees should be directed to Our Customer Service department at 800-422-4234.
- 29. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law.
 - 30. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., InvisalignTM and Sure SmileTM). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).
 - 31. Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.
 - 32. X-ray Limitations:
 - When the frequencies for the comprehensive radiographic images (D0210) and panoramic radiographic images (D0330) differ, the least restrictive frequency will apply.
 - Panoramic images are not considered part of a comprehensive intraoral series.

- Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
- Bitewing x-rays are limited to two images for under age 10.
- Image capture procedures are not separately billable services.

33. Local anesthesia and regional/or trigeminal block anesthesia are not separately payable procedures.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*.
2. Dental conditions arising out of and due to Your employment for which workers' compensation is paid. Services that are provided by state government or agency thereof, or are provided without cost by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the Plan. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.
7. Dispensing of drugs not normally supplied in a dental facility.
8. Any procedure that in the professional opinion of the Contract Dentist or the dental consultant:
 - * 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.
9. Dental services received from any dental facility other than the Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Us or as cited under *Emergency Services*. To obtain written authorization, You should call Our Customer Service department at 800-422-4234.
10. Consultations for non-covered Benefits.
11. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for Dependent Enrollees under 16 years of age.
13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
14. 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).
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. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.
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. Orthodontic treatment must be provided by a licensed Dentist.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.
21. Services or supplies for sleep related breathing disorder/airway management.
22. Photobiomodulation therapy.
23. Administration of neuromodulators.
24. Administration of dermal fillers.

Orthodontic Limitations

This Plan provides coverage for orthodontic treatment plans through Contract Orthodontists. The start-up fees and the cost for the treatment plan are listed in *Schedule A* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee not to exceed \$75.00 per month.
4. Should Your coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, You will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case Your payment will be based on a maximum of \$2,300.00 for Dependent Enrollee children to age 19 and \$2,500.00 for covered Adult Dependents and Dependent Enrollee children to age 26. The amount will be prorated over the number of months to completion of the treatment and, will be payable by You on such terms and conditions as are arranged between You and the Contract Orthodontist.
5. If treatment is not required or You choose not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, You will be charged a consultation fee of \$25.00 in addition to diagnostic record fees.
6. 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, You are responsible for the cost at the Contract Orthodontist's submitted fee.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all the permanent teeth in an effort to make an 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. Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.

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.

3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Treatment related to temporomandibular joint disturbances.
9. Supplemental appliances not routinely used in typical comprehensive orthodontics.
10. Restorative work caused by orthodontic treatment.
11. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
12. Extractions solely for the purpose of orthodontics.
13. Treatment in progress at inception of eligibility.
14. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

More helpful tips for using your plan

Find a network dentist near you

Use our convenient **Find a dentist** tool and select **DeltaCare USA** as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Create an online account at www1.deltadentalins.com/members/welcome-deltacare-usa.html



- Review your plan benefits
- Access your ID card if you want one (You do not need an ID card to receive services.)
- Select or change your dentist at any time

Enjoy the perks of Delta Dental coverage

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You can also get oral health tools and tips at deltadentalins.com/healthylivinghub.

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Need help? Let us know.

Online: Visit deltadentalins.com/ccsf

Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 am to 9 pm ET. Or, use our automated phone system, available 24/7.

Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009



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

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