

CHILDREN'S DENTAL HMO FOR SMALL BUSINESSES

THE RIGHT CHOICE

When it comes to dental benefits, making the right choice can be simple. The DeltaCare[®] USA plan offers a great combination of affordability and dentist access. Our budget-friendly plan is easy to use and can help keep your employees' smiles healthy.

ABOUT DELTACARE USA

During enrollment, each employee will choose a DeltaCare USA dentist to provide services for their family. (Enrollees must see their selected DeltaCare USA dentist to receive benefits.) We'll then send enrollees a welcome packet that includes their ID card and a list of covered dental procedures. This list details the patient's share of the cost – called a copayment – for each procedure. Copayments (where applicable) are payable to the DeltaCare USA dentist at the time of treatment.

Plan features

- ▶ Patients know their copayments up front.
- ▶ No annual deductibles or benefit maximums for covered services.
- ▶ Cleanings and exams are covered at low or no copayment.
- ▶ No claim forms to fill out – enrollees just pay the copayment and leave the rest to us.

Dentists you can trust

- ▶ Your employees can enjoy a long-term relationship with their network dentist. We offer a large choice of dentists and low network turnover.
- ▶ Treating DeltaCare USA dentists coordinate specialty care when needed.
- ▶ Network dentists are carefully screened for quality care and best practices.

This benefit information is only a summary of the important features of the plan coverage; it is not intended or designed to replace or serve as the Group Contract. In the event of any inconsistency between this document and the Group Contract, the terms of the Group Contract will prevail. To view the complete list of covered services and copayments, plus limitations and exclusions contained in the Group Contract, [click here](#) or call 800-471-7583.



ADVANTAGES OF DELTACARE USA

▶ Easy to change dentists

Your employees can change their selected network dentist via our website, by phone or in writing. Requests made by the 21st of the month are effective the first day of the following month.

▶ Coverage for peace of mind

Skipping preventive care can lead to more expensive treatment that could easily cost more than a full year's premium (and could contribute to lost time at work). The DeltaCare USA plan can help your employees stay healthy and avoid more costly care. Plus, our plans provide additional peace of mind with out-of-area dental emergency coverage and zero restrictions on pre-existing conditions (except for work in progress).

▶ Quick and easy online information

Enrollees can manage their accounts online wherever they are – work, home or on the go. Our tools help enrollees access plan information, view claims, find dentists and display ID cards on smartphones and tablets.

▶ Access to the SmileWay[®] Wellness Program

Check out our great oral health resources that can help your employees stay informed and stay healthy. SmileWay offers risk assessment quizzes, articles, videos and a subscription to Grin!, our free dental wellness e-magazine.

Underwritten by

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Administered by

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Customer Service

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DeltaCare[®] USA

Children's Dental HMO for Small Businesses

Plan Highlights

Deductibles & Maximums		Pediatric Benefits (up to age 19)
Deductible	Enrollee	None
Out-of-Pocket Maximum After this amount is reached, the plan pays 100% of the remaining covered services per Contract Year.		\$350 one pediatric enrollee
		\$700 two or more pediatric enrollees

DeltaCare USA provides great dental benefits and predictable costs. The plan provides a full list of copayments¹ so the cost for covered services is never a surprise. Copayments for some of the most common services are listed below.

Sample of Covered Services²

Category	Procedure Code and Description ³	Copayment Amount
		Pediatric Benefits (up to age 19)
Diagnostic & Preventive Services (D & P)	D0999 — Office visit	No cost
	D0120 — Periodic oral exam — established patient	No cost
	D0150 — Comprehensive oral evaluation — new or established patient	No cost
	D0210 — Complete series of x-rays	No cost
	D0220 — Periapical x-ray of tooth's root	No cost
	D0230 — Periapical x-ray of tooth's root, each additional image	No cost
	D0272 — Bitewing x-rays (2 images)	No cost
	D0274 — Bitewing x-rays (4 images)	No cost
	D0330 — Panoramic x-ray	No cost
	D1110 — Prophylaxis (cleaning) — adult	No cost
	D1120 — Prophylaxis (cleaning) — child	No cost
	D1208 — Fluoride treatment	No cost
D1351 — Sealant — per tooth	No cost	
Basic Services	D2140 — Amalgam (silver-colored) filling, 1 surface	\$25
	D2150 — Amalgam (silver-colored) filling, 2 surfaces	\$105
	D2160 — Amalgam (silver-colored) filling, 3 surfaces	\$110
	D2330 — Resin (tooth-colored) filling, front tooth, 1 surface	\$115
	D2331 — Resin (tooth-colored) filling, front tooth, 2 surfaces	\$120
	D2332 — Resin (tooth-colored) filling, front tooth, 3 surfaces	\$135

Category	Procedure Code and Description ³	Copayment Amount
		Pediatric Benefits (up to age 19)
Endodontics	D3310 — Root canal, front tooth	\$300
	D3320 — Root canal, bicuspid tooth	\$300
	D3330 — Root canal, molar tooth	\$300
Periodontics	D4260 — Periodontal surgery, per quadrant	\$350
	D4341 — Periodontal scaling and root planing — four or more teeth per quadrant	\$115
Oral Surgery	D7140 — Extraction (removal) of a fully exposed tooth	\$65
	D7210 — Surgical extraction or erupted (exposed) tooth	\$165
	D7240 — Extraction (removal) of fully impacted tooth, completely bony	\$160
Major Services	D2750 — Crown, porcelain and precious metal	\$350
	D2790 — Crown, precious metal	\$350
	D5110 — Full upper denture	\$350
	D6240 — Bridge pontic, porcelain and precious metal	\$300
	D6750 — Bridge crown, porcelain and precious metal	\$350
Orthodontics	D8080 — Pediatric services — Medically necessary only	\$350

¹ A copayment is the amount the enrollee pays for covered services at the time of treatment.

² Benefits featured above represent the most frequently used services covered under your plan; other services are also covered. After enrollment, the DeltaCare USA plan will make available a complete list of covered services and copayments, along with any limitations and exclusions that apply. Coverage may not be available in all areas. Service area coverage and/or restrictions are listed in the limitations and exclusions.

³ Copayments and procedure descriptions referenced above are intended to clarify the delivery of benefits under the DeltaCare USA plan and are not to be interpreted as CDT-2015 descriptors or nomenclature, which are under copyright by the American Dental Association.

Description of Benefits and Copayments
DeltaCare® USA
Children’s Dental HMO
For Small Businesses

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the plan. **Please refer to *Schedule B* for further clarification of Benefits.**
Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare® USA plan and is not to be interpreted as CDT-2015 procedure codes, descriptors or nomenclature which is 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.

Out-of-Pocket Maximum (OOPM) for Pediatric Enrollees (Under Age 19)

Pediatric Enrollee.....	\$350.00 each Contract Year
Multiple Pediatric Enrollees.....	\$700.00 each Contract Year

OOPM applies only to Essential Health Benefits (EHB) for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Pediatric Benefits under this plan during a Contract Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments (such as precious or semi-precious metals and material upgrades) or that are not covered under the Contract will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered on the Contract, the financial obligation for Pediatric Benefits is not more than the Pediatric Enrollee OOPM. After a Pediatric Enrollee meets his or her OOPM, he or she will have no further payment for the remainder of the Contract Year for Pediatric Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Contract Year for Pediatric Benefits.

Delta Dental recommends that the Pediatric Enrollee or other party responsible keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact the Customer Service department at 800-471-7583.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No cost	<i>Includes office visit, per visit (in addition to other services)</i>
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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D0191	Assessment of a patient	No cost	
D0210	Intraoral - complete series of radiographic images	No cost	<i>Limited to 1 every 24 consecutive months</i>
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	No cost	
D0277	Vertical bitewings - 7 to 8 radiographic images	No cost	
D0330	Panoramic radiographic image	No cost	<i>Limited to 1 every 24 consecutive months</i>
D0460	Pulp vitality tests	No cost	
D0470	Diagnostic casts	No cost	
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	<i>Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office</i>
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	<i>Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office</i>
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	<i>Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office</i>
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No cost	<i>Cleaning; 2 per 12 month period</i>
D1120	Prophylaxis - child	No cost	<i>Cleaning; 2 per 12 month period</i>
D1206	Topical application of fluoride varnish	No cost	<i>2 per 12 month period</i>
D1208	Topical application of fluoride - excluding varnish	No cost	<i>2 per 12 month period</i>
D1310	Nutritional counseling for control of dental disease	No cost	
D1330	Oral hygiene instructions	No cost	
D1351	Sealant - per tooth	No cost	<i>Limited to permanent first and second molars without restorations or decay</i>
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No cost	<i>Limited to permanent first and second molars without restorations or decay</i>
D1353	Sealant repair - per tooth	No cost	<i>Limited to permanent first and second molars without restorations or decay</i>
D1510	Space maintainer - fixed - unilateral	No cost	
D1515	Space maintainer - fixed - bilateral	No cost	
D1520	Space maintainer - removable - unilateral	No cost	
D1525	Space maintainer - removable - bilateral	No cost	
D1550	Re-cement or re-bond space maintainer	No cost	
D1555	Removal of fixed space maintainer	No cost	<i>Included in case by Dentist who placed appliance</i>
D2000-D2999 III. RESTORATIVE			
<i>- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.</i>			
D2140	Amalgam - one surface, primary or permanent	\$25	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2150	Amalgam - two surfaces, primary or permanent	\$105	
D2160	Amalgam - three surfaces, primary or permanent	\$110	
D2161	Amalgam - four or more surfaces, primary or permanent	\$115	
D2330	Resin-based composite - one surface, anterior	\$115	
D2331	Resin-based composite - two surfaces, anterior	\$120	
D2332	Resin-based composite - three surfaces, anterior	\$135	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$165	
D2390	Resin-based composite crown, anterior	\$200	
D2543	Onlay - metallic - three surfaces	\$350	
D2544	Onlay - metallic - four or more surfaces	\$350	
D2710	Crown - resin-based composite (indirect)	\$350	
D2740	Crown - porcelain/ceramic substrate	\$350	
D2750	Crown - porcelain fused to high noble metal	\$350	
D2751	Crown - porcelain fused to predominantly base metal	\$300	
D2752	Crown - porcelain fused to noble metal	\$350	
D2780	Crown - 3/4 cast high noble metal	\$350	
D2781	Crown - 3/4 cast predominantly base metal	\$350	
D2782	Crown - 3/4 cast noble metal	\$350	
D2783	Crown - 3/4 porcelain/ceramic	\$350	
D2790	Crown - full cast high noble metal	\$350	
D2791	Crown - full cast predominantly base metal	\$350	
D2792	Crown - full cast noble metal	\$350	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$65	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$65	
D2920	Re-cement or re-bond crown	\$65	
D2929	Prefabricated porcelain/ceramic crown - primary tooth	No cost	<i>Anterior tooth</i>
D2930	Prefabricated stainless steel crown - primary tooth	\$200	
D2931	Prefabricated stainless steel crown - permanent tooth	\$170	
D2932	Prefabricated resin crown	\$170	<i>When not used in conjunction with any other crown; anterior tooth</i>
D2933	Prefabricated stainless steel crown with resin window	\$150	
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$160	
D2940	Protective restoration	\$30	
D2950	Core buildup, including any pins when required	\$120	
D2951	Pin retention - per tooth, in addition to restoration	\$40	
D2952	Post and core in addition to crown, indirectly fabricated	\$160	<i>Base metal post; includes canal preparation</i>

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2954	Prefabricated post and core in addition to crown	\$140	<i>Includes canal preparation</i>
D2955	Post removal	\$130	
D2970	Temporary crown (fractured tooth)	\$170	
D2980	Crown repair necessitated by restorative material failure	\$130	
D2981	Inlay repair necessitated by restorative material failure	No Cost	
D2982	Onlay repair necessitated by restorative material failure	No Cost	
D2990	Resin infiltration of incipient smooth surface lesions	No Cost	
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	\$40	
D3120	Pulp cap - indirect (excluding final restoration)	\$45	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$85	
D3221	Pulpal debridement, primary and permanent teeth	\$90	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$120	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$120	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$110	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$300	<i>Root canal; per canal</i>
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	\$300	<i>Root canal; per canal</i>
D3330	Endodontic therapy, molar (excluding final restoration)	\$300	<i>Root canal; per canal</i>
D3346	Retreatment of previous root canal therapy - anterior	\$350	<i>Per canal</i>
D3347	Retreatment of previous root canal therapy - bicuspid	\$350	<i>Per canal</i>
D3348	Retreatment of previous root canal therapy - molar	\$350	<i>Per canal</i>
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$140	
D3352	Apexification/recalcification - interim medication replacement	\$140	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$220	
D3410	Apicoectomy - anterior	\$350	<i>Per canal</i>
D3421	Apicoectomy - bicuspid (first root)	\$350	<i>Per canal</i>

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D3425	Apicoectomy - molar (first root)	\$350	<i>Per canal</i>
D3426	Apicoectomy (each additional root)	\$150	<i>Per canal</i>
D3427	Periradicular surgery without apicoectomy	\$350	<i>Per canal</i>
D3430	Retrograde filling - per root	\$120	
D3450	Root amputation - per root	\$170	
D4000-D4999 V. PERIODONTICS			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150	
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	\$350	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$280	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$350	
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$350	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$115	
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$85	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$70	
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$50	
D5000-D5899 VI. PROSTHODONTICS (removable)			
D5110	Complete denture - maxillary	\$350	
D5120	Complete denture - mandibular	\$350	
D5130	Immediate denture - maxillary	\$350	
D5140	Immediate denture - mandibular	\$350	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$350	
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$350	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$350	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$350	
D5410	Adjust complete denture - maxillary	\$50	
D5411	Adjust complete denture - mandibular	\$50	
D5421	Adjust partial denture - maxillary	\$45	
D5422	Adjust partial denture - mandibular	\$50	
D5510	Repair broken complete denture base	\$100	
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$80	
D5610	Repair resin denture base	\$100	
D5620	Repair cast framework	\$130	
D5630	Repair or replace broken clasp	\$110	
D5640	Replace broken teeth - per tooth	\$90	
D5650	Add tooth to existing partial denture	\$100	
D5660	Add clasp to existing partial denture	\$120	
D5710	Rebase complete maxillary denture	\$350	
D5711	Rebase complete mandibular denture	\$350	
D5720	Rebase maxillary partial denture	\$305	
D5721	Rebase mandibular partial denture	\$305	
D5730	Reline complete maxillary denture (chairside)	\$210	
D5731	Reline complete mandibular denture (chairside)	\$210	
D5740	Reline maxillary partial denture (chairside)	\$195	
D5741	Reline mandibular partial denture (chairside)	\$195	
D5750	Reline complete maxillary denture (laboratory)	\$210	
D5751	Reline complete mandibular denture (laboratory)	\$210	
D5760	Reline maxillary partial denture (laboratory)	\$210	
D5761	Reline mandibular partial denture (laboratory)	\$210	
D5850	Tissue conditioning, maxillary	\$100	
D5851	Tissue conditioning, mandibular	\$100	
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered			
D6000-D6199 VIII. IMPLANT SERVICES - Not Covered			
D6200-D6999 IX. PROSTHODONTICS, fixed			
<i>- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)</i>			
D6210	Pontic - cast high noble metal	\$350	
D6211	Pontic - cast predominantly base metal	\$350	
D6212	Pontic - cast noble metal	\$350	
D6214	Pontic - titanium	\$350	<i>Excluding molars</i>
D6240	Pontic - porcelain fused to high noble metal	\$300	
D6241	Pontic - porcelain fused to predominantly base metal	\$350	
D6242	Pontic - porcelain fused to noble metal	\$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D6610	Onlay - cast high noble metal, two surfaces	\$350	
D6611	Onlay - cast high noble metal, three or more surfaces	\$350	
D6612	Onlay - cast predominantly base metal, two surfaces	\$350	
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$350	
D6614	Onlay - cast noble metal, two surfaces	\$350	
D6615	Onlay - cast noble metal, three or more surfaces	\$350	
D6740	Crown - porcelain/ceramic	\$350	
D6750	Crown - porcelain fused to high noble metal	\$350	
D6751	Crown - porcelain fused to predominantly base metal	\$300	
D6752	Crown - porcelain fused to noble metal	\$350	
D6780	Crown - 3/4 cast high noble metal	\$350	
D6781	Crown - 3/4 cast predominantly base metal	\$350	
D6782	Crown - 3/4 cast noble metal	\$350	
D6783	Crown - 3/4 porcelain/ceramic	\$350	
D6790	Crown - full cast high noble metal	\$350	
D6791	Crown - full cast predominantly base metal	\$350	
D6792	Crown - full cast noble metal	\$350	
D6794	Crown - titanium	\$350	
D6930	Re-cement or re-bond fixed partial denture	\$80	
D6940	Stress breaker	\$138	
D6980	Fixed partial denture repair necessitated by restorative material failure	\$200	
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
<i>- Includes preoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.</i>			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$165	
D7220	Removal of impacted tooth - soft tissue	\$225	
D7230	Removal of impacted tooth - partially bony	\$180	
D7240	Removal of impacted tooth - completely bony	\$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$300	
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$165	
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	\$197	
D7286	Incisional biopsy of oral tissue-soft	\$180	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$160	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$130	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$180	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$160	
D7410	Excision of benign lesion up to 1.25 cm	\$175	
D7411	Excision of benign lesion greater than 1.25 cm	\$225	
D7412	Excision of benign lesion, complicated	\$325	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$160	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$300	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$141	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$228	
D7471	Removal of lateral exostosis (maxilla or mandible)	\$350	
D7472	Removal of torus palatinus	\$350	
D7473	Removal of torus mandibularis	\$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	\$110	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$170	
D7520	Incision and drainage of abscess - extraoral soft tissue	\$180	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$225	
D7910	Suture of recent small wounds up to 5 cm	\$150	
D7911	Complicated suture - up to 5 cm	\$205	
D7912	Complicated suture - greater than 5 cm	\$300	
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	\$250	
D7963	Frenuloplasty	\$200	

D8000-D8999 XI. ORTHODONTICS - Medically Necessary

- Orthodontic Services must meet medical necessity as determined by a dentist. Orthodontic treatment is a benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.

- Refer to Schedule B for additional information on Medically Necessary Orthodontics.

Pre-treatment Records after Approved Referral for Thumb Sucking or Tongue Thrust Appliance:

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D0220	Intraoral - periapical first radiographic image	No cost	<i>Anterior only of the affected arch; for orthodontic records only</i>
D0230	Intraoral - periapical each additional radiographic image	No cost	<i>Anterior only of the affected arch; for orthodontic records only</i>
Pre-treatment Records after Approved Referral for Evaluation of Handicapping Malocclusion:			
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No cost	<i>Limited to images with and as a part of a covered pre-orthodontic treatment visit</i>
D0351	3D photographic image	No cost	<i>Limited to images with and as a part of a covered pre-orthodontic treatment visit</i>
D0470	Diagnostic casts	No cost	
Pre-treatment Records with Plan Prior Approval for Comprehensive Orthodontics:			
D0210	Intraoral - complete series of radiographic images	No cost	<i>For covered orthodontic records only</i>
D0322	Tomographic survey	\$100	<i>Only with documentation of medical necessity for</i>
D0340	Cephalometric radiographic image	\$35	
Post-treatment Records after Completion of Covered Comprehensive Orthodontics:			
D0210	Intraoral - complete series of radiographic images	No cost	<i>For covered orthodontic records only</i>
D0340	Cephalometric radiographic image	\$35	<i>Only with documentation of medical necessity for</i>
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No cost	<i>Limited to images with and as a part of a covered orthodontic treatment visit</i>
D0351	3D photographic image	No cost	<i>Limited to images with and as a part of a covered orthodontic treatment visit</i>
D0470	Diagnostic casts	No cost	
D8050	Interceptive orthodontic treatment of the primary dentition	\$350	<i>Limited to Enrollee with a qualifying handicapping malocclusion and a cleft palate or craniofacial anomaly</i>
D8060	Interceptive orthodontic treatment of the transitional dentition	\$350	<i>Limited to Enrollee with a qualifying handicapping malocclusion and a cleft palate or craniofacial anomaly</i>
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$350	
D8210	Removable appliance therapy	\$300	
D8220	Fixed appliance therapy	\$350	
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$75	<i>Limited to 1 per 6 month period when performed by the same Contract Dentist or</i>
D8670	Periodic orthodontic treatment visit	\$75	<i>Included in the orthodontic case fee</i>
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$250	<i>Removable retainer(s); included in the orthodontic case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding</i>
D8691	Repair of orthodontic appliance	\$105	
D8692	Replacement of lost or broken retainer	\$150	
D8693	Re-cement or re-bond fixed retainer	\$68	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D8694	Repair of fixed retainers, includes reattachment	\$68	
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$55	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$35	
D9219	Evaluation for deep sedation or general anesthesia	No cost	
D9220	Deep sedation/general anesthesia - first 30 minutes	\$225	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$95	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	\$45	<i>Per 30 minute increment (where available)</i>
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	\$225	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes	\$95	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>
D9248	Non-intravenous moderate (conscious) sedation	\$120	<i>(Where available)</i>
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$75	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No cost	
D9440	Office visit - after regularly scheduled hours	\$75	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$90	
D9931	Cleaning and inspection of a removable appliance	No cost	
D9986	Missed appointment	\$50	<i>Without 24 hour notice</i>
D9987	Cancelled appointment	\$50	<i>Without 24 hour notice</i>

Endnotes:

Base metal is the benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

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

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

“Filed fees” mean the Contract Dentist’s fees on file with the plan. Questions regarding these fees should be directed to the Customer Service department at 800-471-7583.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the DeltaCare USA dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the DeltaCare USA dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable copayment for the covered procedure.

**Limitations and Exclusions of Benefits
DeltaCare® USA
Children's Dental HMO
For Small Businesses**

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. Diagnostic and Preventive Benefits are limited as follows:
 - a) Bitewing radiographic images in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical radiograph images are allowed on an emergency or episodic basis.
 - b) Full mouth radiographic images in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months.
 - c) Panoramic radiographic images are limited to once every twenty-four (24) consecutive months.
 - d) Caries risk assessment and documentation is limited to Enrollees age 3 to 18; limited to one (1) per thirty-six (36)-month period when performed by same Contract Dentist or office.
 - e) Prophylaxis services (D1110, D1120) (cleanings) are limited to two (2) in a twelve (12)-month period.
 - f) Topical applications of fluoride are limited to two (2) in a twelve (12) month period.
 - g) Dental sealant treatments are limited to permanent first and second molars only. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

2. Restoration Benefits are limited to the following:
 - a) For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations, any other restoration such as a crown or jacket is considered optional.
 - b) Composite resin or acrylic restorations in posterior teeth are optional.
 - c) Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

3. Endodontic Benefits are limited as follows:

Root canal therapy, including culture canal, is limited as follows:

 - a) Re-treatment of root canals is a covered Benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
 - b) Removal or re-treatment of silver points, overfills, underfills, incomplete fills or broken instruments lodged in a canal, in the absence of pathology, is not a covered Benefit.

4. Periodontal Benefits are limited as follows:
 - a) Periodontal scaling and root planing and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.

5. Restorative and fixed prosthodontic onlay, crown and pontic. Benefits are limited as follows:

The crown Benefits are limited as follows:

 - a) Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the dental plan.

- b) Only acrylic crowns and stainless steel crowns are a Benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional Benefit for children under twelve (12) years of age, the covered dental Benefit level will be that of an acrylic crown.
- c) Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- d) Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- e) Porcelain/ceramic crowns and pontics on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit. For a covered porcelain-fused-to-metal crown or pontic, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of \$75 per unit.

The fixed bridge Benefits are limited as follows:

- a) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- b) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on an Enrollee under the age of sixteen (16), the Enrollee must pay the difference in cost between the fixed bridge and a space maintainer.
- c) 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.
- d) Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- e) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- f) The plan allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.
- g) Porcelain/ceramic fixed bridge retainers on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit.

6. Removable Prosthetic Benefits are limited as follows:

- a) Partial dentures will not be replaced within thirty-six (36) consecutive months unless:
 - 1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
 - 2) The denture is unsatisfactory and cannot be made satisfactory.
- b) The covered dental Benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the Enrollee and the Contract Dentist, and is not necessary to satisfactorily restore an arch, the Enrollee will be responsible for all additional charges.
- c) A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- d) Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
- e) The covered dental Benefit for complete dentures will be limited to the Benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- f) Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.

- g) Tissue conditioning is limited to two (2) per denture.
 - h) Implants are considered an optional benefit.
 - i) Stayplates are a Benefit only when used as anterior space maintainers for children.
7. Oral surgery limitation:
- a) The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
8. Other Benefits are limited as follows:
- a) Oral sedatives are limited to those dispensed in a dental office by a practitioner acting within the scope of their licensure.
 - b) Nitrous oxide is limited to when it is dispensed in a dental office by a practitioner acting within the scope of their licensure.
 - c) A broken appointment charge will be applied in a fair and reasonable manner and will not apply in exigent circumstances where advance notice of cancellation was not reasonably possible.
9. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/ that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$325 in addition to the listed Copayment. Contact the Customer Service department at 800-471-7583 if you have questions regarding the additional fee or name brand services.

Exclusions of Benefits for Pediatric Enrollees

The following dental services are excluded under the plan:

1. Services which, in the opinion of the Contract Dentist, are not necessary to the Enrollee's dental health.
2. Procedures, appliances or restorations to correct congenital or developmental malformations are not covered Benefits unless specifically listed under *Schedule A, Description of Benefits and Copayments*.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation, unless specifically listed as a Benefit or is given by a DeltaCare USA Contract Dentist for covered oral surgery.
5. Experimental or investigational procedures.
6. Dental conditions arising out of and due to an Enrollee's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need and the Enrollee shall cooperate to ensure that the participating dental plan is reimbursed for such Benefits.
7. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.
8. All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
9. Major surgery for fractures and dislocations.
10. Loss or theft of dentures, fixed partial dentures (bridgework) or other appliances.

11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Enrollee became eligible for such services.
12. Any service that is not specifically listed as a covered Benefit under *Schedule A, Description of Benefits and Copayments*.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the Contract Dentist's office due to the general health and physical limitations of the Enrollee.
16. The cost of precious metals used in any form of dental Benefits.
17. The surgical removal of implants.
18. Services of a pedodontist/pediatric dentist for an Enrollee, except when the Enrollee is unable to be treated by his or her primary care Contract Dentist, or treatment by a pedodontist/pediatric dentist is medically necessary.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan or dental plan. The participating dental plan shall provide the services at the time of need and the Enrollee shall cooperate to ensure that the participating dental plan is reimbursed for such Benefits.
20. Consultations or other diagnostic services for non-covered Benefits.

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts. Comprehensive orthodontic treatment:
 - a) is limited to Enrollees who are between 13 to 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
 - b) may start at birth for patients with a cleft palate or craniofacial anomaly.
2. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.
3. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0351). Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment visit.
4. The number of covered periodic orthodontic treatment visits and length of covered active orthodontics is limited to a maximum of up to:
 - a) Handicapping malocclusion - Eight (8) quarterly visits;
 - b) Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;
 - c) Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or
 - d) Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.
 - e) Facial growth management – Four (4) quarterly visits for treatment of primary dentition;
 - f) Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;
 - g) Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment which:
 - a) Includes removal of appliances and the construction and place of retainer(s); and
 - b) is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
 - a. will not be entitled to a refund of any amounts previously paid, and
 - b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

- a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
- b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the Quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

Service Areas

Coverage is available in the following counties in California:

Full Counties (plan available anywhere in the county):

Alameda
Colusa
Contra Costa
Glenn
Kings
Lake
Los Angeles
Madera
Marin
Merced
Monterey
Napa
Orange
Sacramento
San Benito
San Francisco
San Joaquin
San Luis Obispo
Santa Barbara
Santa Clara
Solano
Stanislaus
Sutter
Tulare
Ventura
Yolo
Yuba

Partial counties (plan only available in certain areas of the county):

Amador
Butte
Calaveras
El Dorado
Fresno
Humboldt
Imperial
Inyo
Kern
Mariposa
Mendocino
Nevada
Placer
Plumas
Riverside
San Bernardino
San Diego
Shasta
Sierra
Sonoma
Tehama
Trinity
Tuolumne