Delta Care USA DHMO DENTAL PLAN*

ENROLLMENT INSTRUCTIONS

Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.

MEMBER / APPLICANT INFORMATION:

Member/Applicant: _____

Local REALTOR ® Assoc. Name: _____

E-Mail Address: _____

Requested effective date of coverage: 1st of _____

New Enrollee [ ] **Current Benefits Store Member Changing Plans [ ]**

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association or a W2 Employee of a member firm.

SELECTING YOUR PLAN:

[ ] Delta Care USA DHMO

COMPLETING THE APPLICATION:

USE BLACK INK AND COMPLETE ALL SECTIONS

EFFECTIVE DATE OF COVERAGE:

Applications are accepted (must be received in our office) be the 15th of the current month for coverage to be effective the 1st of the following month.

To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.

Applications are batched by group to the insurers monthly. Any application received after the 15th of the current month will be part of the next month's application batch.

TO ENROLL:

Review the application for accuracy, sign, date, and return to us with your premium.
Make checks Payable to The Benefits Store Trust Account.

U.S. MAIL(1St Class or Priority)
ATTN: ENROLLMENT
Benefits Store, Inc.
PO Box 238, Alamo, CA 94507

PROCESSING REQUIREMENT:

NOTE: Incomplete applications or applications without the correct premium included cannot be processed.

One (1) months premium is required with your application.

Delta Care USA DHMO DENTAL PLAN*

ENROLLMENT INSTRUCTIONS

PREMIUM PAYMENTS:

(4) ways to pay your monthly premium:

Electronic Funds Transfer (EFT)
Monthly Invoice/Check
On-Line Bill Payment
Credit Card Payment/Visa, MasterCard, Discover or American Express

For your convenience we have included an EFT Authorization and a Credit Card Authorization Form with the Enrollment Form.

APPLICATION PROCESSING:

Allow 7 business days after the 15th of the current month for the processing of your application and for you to appear in the Dental Plan's database. An Email Confirmation will be automatically generated to you with your group policy number and plan information. DON'T DELAY – ENROLL TODAY! To avoid this delay we urge you to submit your application to us as soon as possible.

You should not cancel your current coverage until you are notified of your new coverage.

For verification of your new coverage, E-mail:

Enrollment@BenefitsStore.com

*This program is a special benefit for members of local REALTOR® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.

DELTACARE®

ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY

Group No. _____

Contract Type _____

Effective Date _____

Check One

- ❑ New Enrollment
- ❑ Name Change
- ❑ Facility Change*
- ❑ COBRA
- ❑ New Social Security Number/ Employee ID Number
- ❑ Address Change
- ❑ Add Dependent
- ❑ Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

(Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Widowed
- ❑ Surviving Dependent
- ❑ Divorce
- ❑ Overage Dependent

Indicate qualifying date:

(Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last) (First) (M.I.)

Mailing Address: (Street Address)

(City) (State) (Zip Code)

E-mail Address:

Date of Birth: (Month) (Day) (Year)

Male ❑ Female ❑

Home Phone #: ( ) –

Name of Employer/Group:

Location:

Soc. Security #: – –

Employee Identification #:

Contract Facility Name:

Contract Facility #:

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female (Check One) M	F	Date of Birth (Month) (Day) (Year)	Contract Facility Name	Contract Facility #:
		❑	❑			
		❑	❑			
		❑	❑			
		❑	❑			
		❑	❑			
		❑	❑			
		❑	❑			

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:
Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

Signature of Primary Enrollee _____ Date _____

The Benefits Store, Inc.

Association Benefits CA License No. 0680704

Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information	Payment Selection
Name:	CCA [ ] EFT / ACH [ ]
Email:	

Credit Card Transaction

Credit Card Information: Visa [ ] Mastercard [ ] Discover [ ] American Express [ ]

Card Number: ____-____-____-____ ____-____-____-____ ____-____-____-____ ____-____-____-____ **Exp: (MM / YY):** ____-____ / ____-____

Name (as appears on the card): **Authorization Code:** ____-____-____

Address: **City:** **State:** **Zip:**

Monthly Recurring Charges: I authorize the Benefits Store to charge this credit card for the monthly premium on the 20th of each month.
Yes [ ] No [ ] Initials: _____

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

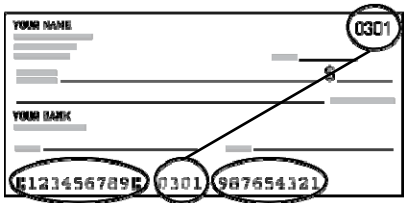
Name on Account: **Name of Financial Institution:**

Routing Number (9 digits): ___-___-___-___-___-___-___-___-___ **Account Number:** ___-___-___-___-___-___-___-___-___-___-___-___-___-___-___

Account Holder Type: Personal [ ] Business [ ] **Account Type:** Checking [ ] Savings [ ]

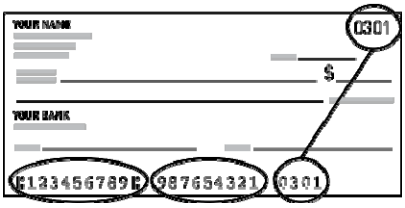
Determining your routing number:
To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Bank 1



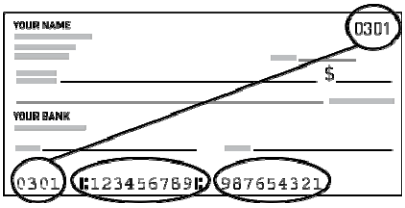
Routing # Check # Account #

Bank 2



Routing # Account # Check #

Bank 3



Check # Routing # Account #

I authorize the Benefits Store to deduct the monthly premium from this bank account.

Yes [ ] No [ ] Initials: _____ 5th of the Month [ ] 15th of the Month [ ]

Monthly Recurring Charges (EFT)

Payment Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above. I will not hold The Benefits Store, Inc. responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository/credit institution.

Monthly Transactions Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to The Benefits Store, Inc. or upon the termination of the coverage through The Benefits Store, Inc. Should a rate change due to policy renewal, age band change or coverage tier occur, I authorize The Benefits Store, Inc. to automatically make the adjustment to my monthly deduction.

Note: I understand and authorize a $25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature:	Date:
Payment Amount:	$ _____

The Benefits Store, Inc. - PO Box 238 Alamo, CA 94507 - Membership / Accounting : 800-446-2663 - Email: CustomerService@BenefitsStore.com

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, INC.
CA Insurance License #0680704

IMPORTANT NOTICE

NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS
PHONE NUMBER: (888) 226-8373 FAX: (925) 855-2051
EMAIL: BILLING@BENEFITSSTORE.COM
MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING
PO Box 238
Alamo, CA 94507

Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)
You may do a one time transaction or monthly deduction.

RELIABLE!
EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!
All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EFT MONTHLY PAYMENTS!
You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

SIMPLE!
Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

Monthly Invoice / Check
Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1st and payable (received) on or before June 20th.

Late fees are charged for payments received after the 20th.

Your full payment must be received by the 20th to avoid a late charge. We suggest that you mail your payment on or before the 12th of each month

Payments **MUST** be mailed to:
The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.

On-Line Bill Payment
Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service
www.Bankofamerica.com
B of A - Online Banking Info

www.Wellsfargo.com
Wells Fargo - Online Banking Information

Your full payment must be received by the 20th to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10th of each month.

Payments **MUST** be mailed to:
The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.

Credit Card Payment Visa or MasterCard
Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site www.BenefitsStore.com

To do so, click on the "Forms" tab located in the bar crossing our home page or select the following link Credit Card Authorization Form

Your full payment must be received by the 20th to avoid a late charge. We suggest you initiate your credit card payment on or before the 17th of each month.

For processing, Credit Card Authorization forms must be faxed to (925) 855-2051

Contact us at (888) 226-8373 with any questions about completing this form.

DeltaCare® USA – provided by Delta Dental of California

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

Find a DeltaCare USA dentist

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

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

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

Welcome to DeltaCare USA — quality, convenience, predictable costs

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

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

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

Quality

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

Convenience

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

Predictable costs

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

DELTA DENTAL®

Administered by Delta Dental Insurance Company

What if I have questions about my DeltaCare USA Program?

Eligibility for you and your family

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

Easy enrollment

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

How your DeltaCare USA program works

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

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

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

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

Provisions for emergency care

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

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

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

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

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

Can I change my contract dentist?

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

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

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

Highlights of your DeltaCare USA Program

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

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

How does the DeltaCare USA program encourage preventive care?

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

Does my DeltaCare USA program cover specialists' services?

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

What if I have questions about my DeltaCare USA program?

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

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

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2014 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	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 - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 1 per 6 month period*	No Cost
D1208	Topical application of fluoride - *child to age 19; 1 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1510	Space maintainer - fixed - unilateral	$25.00
D1515	Space maintainer - fixed - bilateral	$25.00
D1520	Space maintainer - removable - unilateral	$25.00
D1525	Space maintainer - removable - bilateral	$25.00
D1550	Re-cementation of space maintainer	No Cost
D1555	Removal of fixed space maintainer	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 or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior [1, 2]	Optional
D2392	Resin-based composite - two surfaces, posterior [1, 2]	Optional
D2393	Resin-based composite - three surfaces, posterior [1, 2]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [1, 2]	Optional
D2510	Inlay - metallic - one surface [3, 4]	No Cost
D2520	Inlay - metallic - two surfaces [3, 4]	No Cost
D2530	Inlay - metallic - three or more surfaces [3, 4]	No Cost
D2542	Onlay - metallic - two surfaces [3, 4]	No Cost
D2543	Onlay - metallic - three surfaces [3, 4]	No Cost
D2544	Onlay - metallic - four or more surfaces [3, 4]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [2, 4]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces [2, 4]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces [2, 4]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [2, 4]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [2, 4]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [2, 4]	Optional
D2650	Inlay - resin-based composite - one surface [2, 4]	Optional
D2651	Inlay - resin-based composite - two surfaces [2, 4]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [2, 4]	Optional
D2662	Onlay - resin-based composite - two surfaces [2, 4]	Optional
D2663	Onlay - resin-based composite - three surfaces [2, 4]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [2, 4]	Optional
D2710	Crown - resin-based composite (indirect) [4, 5]	$50.00
D2712	Crown - ¾ resin-based composite (indirect) [4, 5]	$50.00
D2720	Crown - resin with high noble metal [3, 4, 5]	$90.00
D2721	Crown - resin with predominantly base metal [4, 5]	$90.00
D2722	Crown - resin with noble metal [4, 5]	$90.00
D2740	Crown - porcelain/ceramic substrate [4, 5]	$90.00
D2750	Crown - porcelain fused to high noble metal [3, 4, 5]	$90.00
D2751	Crown - porcelain fused to predominantly base metal [4, 5]	$90.00
D2752	Crown - porcelain fused to noble metal [4, 5]	$90.00
D2780	Crown - ¾ cast high noble metal [3, 4]	$90.00
D2781	Crown - ¾ cast predominantly base metal [4]	$90.00
D2782	Crown - ¾ cast noble metal [4]	$90.00
D2790	Crown - full cast high noble metal [3, 4]	$90.00
D2791	Crown - full cast predominantly base metal [4]	$90.00
D2792	Crown - full cast noble metal [4]	$90.00
D2794	Crown - titanium [3, 4]	$90.00
D2910	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost
D2920	Recement crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior primary tooth*	$15.00
D2930	Prefabricated stainless steel crown - primary tooth	$5.00

D2931	Prefabricated stainless steel crown - permanent tooth	$5.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$15.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$15.00
D2940	Protective restoration	$15.00
D2941	Interim therapeutic restoration - primary dentition	$15.00
D2949	Restorative foundation for an indirect restoration	$15.00
D2950	Core buildup, including any pins when required	$15.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [3]	$15.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [3]	$15.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$15.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$15.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$18.00
D2980	Crown repair necessitated by restorative material failure	$15.00
D2981	Inlay repair necessitated by restorative material failure	$15.00
D2982	Onlay repair necessitated by restorative material failure	$15.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$10.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$10.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [6]	$45.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) [6]	$90.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration) [6]	$135.00
D3346	Retreatment of previous root canal therapy - anterior [6]	$65.00
D3347	Retreatment of previous root canal therapy - bicuspid [6]	$110.00
D3348	Retreatment of previous root canal therapy - molar [6]	$155.00
D3410	Apicoectomy - anterior [6]	$60.00
D3421	Apicoectomy - bicuspid (first root) [6]	$60.00
D3425	Apicoectomy - molar (first root) [6]	$60.00
D3426	Apicoectomy (each additional root) [6]	No Cost
D3427	Periradicular surgery without apicoectomy	$60.00
D3430	Retrograde filling - per root [6]	$60.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [6]	No Cost

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$125.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$25.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$25.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$125.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$125.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$250.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$250.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$15.00

D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$15.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$15.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$12.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [7, 8]	$110.00
D5120	Complete denture - mandibular [7, 8]	$110.00
D5130	Immediate denture - maxillary [7, 8]	$125.00
D5140	Immediate denture - mandibular [7, 8]	$125.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [7, 8]	$125.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [7, 8]	$125.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [7, 8]	$125.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [7, 8]	$125.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [7, 8]	$175.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [7, 8]	$175.00
D5410	Adjust complete denture - maxillary [7]	$10.00
D5411	Adjust complete denture - mandibular [7]	$10.00
D5421	Adjust partial denture - maxillary [7]	$10.00
D5422	Adjust partial denture - mandibular [7]	$10.00
D5510	Repair broken complete denture base	$20.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5610	Repair resin denture base	$20.00
D5620	Repair cast framework	$20.00
D5630	Repair or replace broken clasp	$20.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture	$10.00
D5710	Rebase complete maxillary denture [9]	$45.00
D5711	Rebase complete mandibular denture [9]	$45.00
D5720	Rebase maxillary partial denture [9]	$45.00
D5721	Rebase mandibular partial denture [9]	$45.00
D5730	Reline complete maxillary denture (chairside) [9]	$20.00
D5731	Reline complete mandibular denture (chairside) [9]	$20.00
D5740	Reline maxillary partial denture (chairside) [9]	$20.00
D5741	Reline mandibular partial denture (chairside) [9]	$20.00
D5750	Reline complete maxillary denture (laboratory) [9]	$45.00
D5751	Reline complete mandibular denture (laboratory) [9]	$45.00
D5760	Reline maxillary partial denture (laboratory) [9]	$45.00
D5761	Reline mandibular partial denture (laboratory) [9]	$45.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [7]	No Cost
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [7]	No Cost
D5850	Tissue conditioning, maxillary [7, 9]	No Cost
D5851	Tissue conditioning, mandibular [7, 9]	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 [3, 10]	$90.00
D6211	Pontic - cast predominantly base metal [10]	$90.00
D6212	Pontic - cast noble metal [10]	$90.00
D6240	Pontic - porcelain fused to high noble metal [3, 5, 10]	$90.00
D6241	Pontic - porcelain fused to predominantly base metal [5, 10]	$90.00
D6242	Pontic - porcelain fused to noble metal [5, 10]	$90.00
D6245	Pontic - porcelain/ceramic [2, 10]	Optional
D6250	Pontic - resin with high noble metal [3, 5, 10]	$90.00
D6251	Pontic - resin with predominantly base metal [5, 10]	$90.00
D6252	Pontic - resin with noble metal [5, 10]	$90.00
D6600	Inlay - porcelain/ceramic, two surfaces [2, 10]	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces [2, 10]	Optional
D6602	Inlay - cast high noble metal, two surfaces [3, 10]	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces [3, 10]	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces [10]	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces [10]	No Cost
D6606	Inlay - cast noble metal, two surfaces [10]	No Cost
D6607	Inlay - cast noble metal, three or more surfaces [10]	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces [2, 10]	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces [2, 10]	Optional
D6610	Onlay - cast high noble metal, two surfaces [3, 10]	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces [3, 10]	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces [10]	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces [10]	No Cost
D6614	Onlay - cast noble metal, two surfaces [10]	No Cost
D6615	Onlay - cast noble metal, three or more surfaces [10]	No Cost
D6720	Crown - resin with high noble metal [3, 5, 10]	$90.00
D6721	Crown - resin with predominantly base metal [5, 10]	$90.00
D6722	Crown - resin with noble metal [5, 10]	$90.00
D6740	Crown - porcelain/ceramic [2, 10]	Optional
D6750	Crown - porcelain fused to high noble metal [3, 5, 10]	$90.00
D6751	Crown - porcelain fused to predominantly base metal [5, 10]	$90.00
D6752	Crown - porcelain fused to noble metal [5, 10]	$90.00
D6780	Crown - ¾ cast high noble metal [3, 10]	$90.00
D6781	Crown - ¾ cast predominantly base metal [10]	$90.00
D6782	Crown - ¾ cast noble metal [10]	$90.00
D6790	Crown - full cast high noble metal [3, 10]	$90.00
D6791	Crown - full cast predominantly base metal [10]	$90.00
D6792	Crown - full cast noble metal [10]	$90.00
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker [10]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$15.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	$3.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$3.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$8.00
D7220	Removal of impacted tooth - soft tissue	$40.00

D7230	Removal of impacted tooth - partially bony	$60.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$80.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$80.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [11]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [11]	$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [11]	$1,800.00
D8660	Pre-orthodontic treatment visit - *not to be charged with any other consultation procedure(s)* [12]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [13]	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding*	$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$10.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

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

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

FOOTNOTES

1 *An amalgam is the benefit.*

2 *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 the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding the DeltaCare USA program should be directed to Delta Dental's Customer Service department at 800-422-4234.*

3 *Base or noble metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.*

4 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

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

6 *A benefit for permanent teeth only.*

7 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

8 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

9 *Limited to 1 per denture during any 12 consecutive months.*

10 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

11 *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.*

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

13 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. If a biopsy is preauthorized by Delta Dental 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.
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 five year limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects 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.
10. 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 the Enrollee elects 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.
11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. Either of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
18. 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 (see Limitation #12) **or**
        - Each abutment tooth to be crowned meets Limitation #8.
    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 (see Limitation #12).

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.

20. 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.

21. Retained primary teeth shall be covered as primary teeth.

22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

24. In cases of accidental injury, benefits available are described in *Schedule B, 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, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*

25. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.

26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

27. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure.

Exclusions of Benefits

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

2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.

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 the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.

7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.

8. Dispensing of drugs not normally supplied in a dental facility.

9. Any procedure that in the professional opinion of the Contract Dentist:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.

10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services.* To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at 800-422-4234.

11. Consultations for non-covered benefits.

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

15. 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).

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services.

17. 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.

18. 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.

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

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

1. Orthodontic treatment must be provided by a Contract Orthodontist.

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 to the Enrollee not to exceed $75.00 per month.

4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 23. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

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, the Enrollee is responsible for the cost at the Contract Orthodontist's "filed fees."

7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

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

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
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. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.
12. 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.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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, Description of Benefits and Copayments*.

Delta Dental will pay up to 100 percent of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

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, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.

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

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

SmileWay® Wellness Program

Find all of our dental health resources, including a risk assessment tool, articles, videos and a free e-newsletter subscription, at: **mysmileway.com**.

DeltaCare USA Customer Service

800-422-4234

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

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

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

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

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

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

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