DeltaCare® USA

Disclosure Form/Contract

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234
deltadentalins.com

Delta Dental Insurance Company provides Benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes

DISCLOSURE FORM/CONTRACT ("CONTRACT")

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

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

This booklet discloses the terms and conditions of the Program available in Florida. **PLEASE READ THE ENTIRE DOCUMENT COMPLETELY AND CAREFULLY.** You have a right to review this Contract prior to enrollment.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIST SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

Benefits for preexisting conditions (e.g. missing teeth) are covered under the DeltaCare USA Program. However, Benefits are not provided for dental treatment in progress at inception of eligibility in this Program. Refer to Exclusion of Benefits #18.

ADDITIONAL INFORMATION ABOUT YOUR BENEFITS IS AVAILABLE BY CALLING THE CUSTOMER SERVICE DEPARTMENT AT 800-422-4234, 8 a.m. – 9 p.m. EASTERN TIME, MONDAY THROUGH FRIDAY.

Russell L. Aracich
Vice President, Sales Southeast

DeltaCare® USA

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alphabetta, GA 30009

INDIVIDUAL/FAMILY DENTAL PROGRAM
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Check One

- ❑ New Enrollment
- ❑ Name Change
- ❑ Facility Change*
- ❑ Address Change
- ❑ Add Dependent
- ❑ Remove Dependent

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

Month ___ Day ___ Year ___

Broker#: ____________

ENROLLMENT SECTION

Please complete Payment Authorization Section

VERY IMPORTANT - PLEASE PRINT LEGIBLY

Your Full Name: ______________________ (Last / First / MIddle)

Mailing Address: ______________________ (Street / City / State & Zip)

Date of Birth: ____________ Male ❑ Female ❑ Home Phone: (_____) __________ Identification #: ______________

Contract Facility name: ______________________ Contract Facility #: ____________

Dependent Information *Please list all dependents to be covered. If additional space is needed attach a separate sheet.*

Relationship Code*	DEPENDENT NAME (include last name only if different than yours)	BIRTHDATE Mo/Day/Year	SEX	DEPENDENT STATUS
__|__	SPOUSE		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete
__|__	CHILD		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete
__|__	CHILD		❑ Male ❑ Female	❑ Current ❑ New ❑ Delete

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

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

Dental benefits are provided by the Contract Facility selected above. A list of contract dentists is furnished with the Contract or is available at deltadentalins.com. Treatment received from an out-of-network Dentist is not covered except as otherwise described in this Contract.

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

Enrollment is also available through our web site: deltadentalins.com

FLA44

PAYMENT AUTHORIZATION SECTION

Please complete Enrollment Section

PROGRAM COST AND PAYMENT OPTION (choose only one)

		Annual
❑	Enrollee Premium	**$120.00**
❑	Enrollee plus one dependent	**$220.00**
❑	Enrollee plus two or more dependents	**$280.00**
❑	One-time Enrollment Fee	**$ 15.00**
	TOTAL	**$_______**

Additional information regarding Program Costs and Payment Options can be found on page 4 of this booklet.

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

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

PAYMENT OPTIONS

❑ **CHECK/MONEY ORDER PAYMENT OPTION**

Please make check or money order payable to the Administrator of the Program, Delta Dental Insurance Company. You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of Benefits.

❑ **CREDIT CARD PAYMENT OPTION**

❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

CARD # ________________________________

EXPIRATION DATE ________________________________

NAME AS IT APPEARS ON THE CARD

____

SIGNATURE ________________________________

DATE ________________________________

By signing above you authorize the Administrator to charge your credit card account for the cost of the Program. This authority shall remain in effect to renew your annual enrollment unless you give written notification of termination 30 days prior to the expiration of the contract term.

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

Have you selected a Contract Dentist? If not, we will assign you to a facility near your home.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

________________________________ Signature of Applicant

________________________________ Date

FLA44

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Definitions

As used in this Contract:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Delta Dental, operating as an Administrator in the state of Florida. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

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

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

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

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

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

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

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

Copayment means the amount charged to an Enrollee by a Contract Dentist, Contract Orthodontist or Contract Specialist for the Benefits provided under this Program.

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

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

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

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

Emergency Services mean only those dental services immediately required to alleviate severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious danger.

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

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

Premium means the amount payable as provided in this Contract.

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

Usual Fee means the fee that an individual Dentist most frequently charges for a given dental service.

We, Us or Our means Delta Dental Insurance Company.

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

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

How to use the Program - Choice of Contract Dentist

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

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

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

Who is eligible for coverage?

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

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

Your Eligible Dependents include:

1) spouse (unless legally separated or divorced) or Domestic Partner (until such partnership is terminated by either or both parties);
2) unmarried children from birth up to age 19; and dependent grandchildren until age 18 months;
3) unmarried, dependent children from age 19 until the end of the calendar year in which they turn 25 if they are wholly dependent on you for support AND are either full or part-time students in an accredited school or are living in your household.

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

An unmarried child over the age of 19 may remain eligible if that child is incapable of self-support because of a physical disability or mental incapacity and is chiefly dependent on you for support and maintenance. See *Renewal, Cancellation and Termination of Benefits*.

How do I enroll?

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

How much do I pay?

	The Premium for the initial Contract Term is:	**Annual**
*	Primary Enrollee only (one person): *plus a one-time enrollment fee of $15.00*	$120.00
*	Primary Enrollee and one dependent (spouse or child): *plus a one-time enrollment fee of $15.00*	$220.00
*	Primary Enrollee and two or more dependents: *a one-time enrollment fee of $15.00*	*plus* $280.00

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

1) The one-time enrollment fee is not refundable after the first month of coverage;
2) You have not received any Benefits under the Program;
3) there is at least one month remaining in the Contract Term;
4) coverage is based on a full calendar month. There are no partial month refunds.

Choose a Payment Option

Delta Dental gives you two easy payment options. Your annual Premium may be charged to your MasterCard, Visa, Discover or American Express account. Or, you may pay by personal check or money order. Be sure to indicate which payment option you have chosen.

* **Credit Card Payment Option**
  Under this option, your annual Premium and the $15.00 one-time enrollment fee will be charged to your MasterCard, Visa, Discover or American Express account.

* **Check/Money Order Payment Option**
  If you choose this option, make your check payable to Delta Dental Insurance Company. Checks returned for insufficient funds are subject to a $25.00 processing fee which must be paid before coverage will be reinstated.

Mailing Instructions

Please mail the completed *Enrollment and Payment Authorization Form* with either credit card information or a check or money order for the Premium and the $15.00 enrollment fee to:

Delta Dental Insurance Company
P.O. Box 660138
Dallas, TX 75266-0138

What will my Effective Date be?

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

Emergency Services

Your assigned Contract Dentist maintains a 24-hour Emergency Services system seven days a week. The Contract Dentist will provide Emergency Services for covered procedures whenever possible. If you require Emergency Services and are 35 miles or more from your Contract Dentist's facility, or you are unable to reach your Contract Dentist, you may seek treatment from a Dentist other than your assigned Contract Dentist. Benefits for emergency treatment provided by an out-of-network Dentist are subject to a $100.00 maximum per emergency, per Enrollee. You will be responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

YOUR ASSIGNED CONTRACT DENTIST MUST PROVIDE EMERGENCY CARE FOR COVERED SERVICES IF YOU ARE WITHIN 35 MILES OF HIS OR HER FACILITY.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist. You will pay for all Specialist Services, which are Benefits provided by a Contract Specialist, directly to the Contract Specialist. (Refer to *Schedule A.)* If there is not an available Contract Specialist in the area, there are no Benefits for Specialist Services.

SPECIALIST SERVICES PERFORMED BY AN OUT-OF-NETWORK DENTIST ARE NOT COVERED.

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

What if I need to change Contract Dentists?

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

All treatment in progress must be completed before you change to another Contract Dentist. For example, this would include (a) partial or full dentures for which final

impressions have been taken, (b) completion of root canals in progress and (c) delivery of crowns when teeth have been prepared.

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

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A*. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice) and charges for visits after normal visiting hours are listed in *Schedule A*.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for provisions in *Emergency Services*, we will not pay a Dentist who is not a Contract Dentist, therefore, if you have received treatment from an out-of-network Dentist, you will be liable to that Dentist for the cost of services. For further clarification, see *Emergency Services* and *Specialist Services*.

Claims for Reimbursement

Claims for covered Emergency Services should be sent to us within 90 days of the end of treatment. Valid claims will be reviewed after 90 days if you can show that it was not reasonably possible to submit the claim within that time. Late claims must be submitted as soon as possible. Except in the absence of legal capacity of the claimant, all claims must be received within one year of the treatment date.

Enrollee Complaint Procedure

Informal Grievances

An Enrollee who has a grievance against Delta Dental for any matter arising out of this Contract may make an informal complaint by calling the toll-free number 800-422-4234. A grievance is not considered formal until Delta Dental receives a written complaint.

Formal Grievances

Written complaints may be addressed to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

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

Within 10 business days of the receipt of any complaint a quality management coordinator will forward to the complainant an acknowledgement of receipt of the complaint. Certain requests may require that the complainant be referred to a Dentist in their area for clinical evaluation of the dental services provided.

Delta Dental will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. In no event will the decision on the request for review be sent more than 90 days after Delta Dental receives it.

Appeal of Decision

A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. Delta Dental shall undertake a full and fair review upon any request. Delta Dental may require additional documents as it deems necessary in making such a review. Delta Dental shall provide a written response to the complainant within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the decision.

An Enrollee who is dissatisfied with the decision may appeal in writing to the State of Florida Office of Insurance Regulation.

The State of Florida Office of Insurance Regulation may be contacted at any time, concerning any complaint or request for assistance, by writing to 200 East Gaines St., Tallahassee, FL 32399, or by calling the Office's toll-free consumer hotline: 800-342-2762.

Renewal, Cancellation and Termination of Benefits

No change in Benefits or Premium will be made during a Contract Term. We will send you a written renewal notice, including any proposed changes in Benefits and/or Premium at least 60 days before your coverage expires. Your desire to renew the Contract is indicated by payment of the renewal Premium prior to the end of the Contract Term. If you do not send the renewal Premium by this time, we will assume that you do not wish to continue coverage. In this case, Benefits will terminate at the end of the Contract Term.

Receipt of the applicable Premium by us after termination of your coverage will reinstate your coverage unless payment is received more than 15 days after termination and we refund such payment within 20 business days. You may request reinstatement of coverage for up to one year following the expiration of your Contract Term. However, reinstated coverage will always be retroactive to the date immediately following the end of the previous Contract Term. If a later date is requested, which would result in a gap in coverage, you must complete new enrollment forms and pay the enrollment fee as well as the annual Premium.

Subject to the Extension of Benefits provision below, Delta Dental will cancel enrollment in the following events:

Immediately:

1) For any Eligible Dependent, upon receipt of a written notice regarding the loss of dependent status; however, an unmarried dependent child may continue eligibility if:
   a) he or she is incapable of self-support because of a physical disability or mental incapacity that began prior to reaching the limiting age;
   b) he or she is chiefly dependent on you for support, and
   c) proof of dependent's disability or incapacity is provided within 31 days of request by Delta Dental and subsequently as required. Such requests will not be made more than once a year after the Eligible Dependent reaches age 25;

Upon 45 days written notice if:

1) the Program is terminated by Delta Dental at the end of the annual Contract Term because of our decision not to renew the Contract;
2) the Enrollee's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that their continuing participation seriously impairs the organization's ability to provide services to other Enrollees;
3) the Enrollee commits fraud or misrepresentation in applying for or presenting any claim for Benefits under the Contract;
4) the Enrollee misuses the documents provided as evidence of Benefits available under the Contract; or
5) the Enrollee furnishes incorrect or incomplete information to Delta Dental in order to fraudulently obtain services.

Prior to cancellation, Delta Dental will make every effort to resolve problems through the grievance procedures and will determine that your behavior is not due to the use of the services or mental illness.

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

Grace Period

A grace period of 30 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Contract will continue in force. If your coverage terminates for non-payment, you will be responsible for the cost of services rendered during that grace period.

Extension of Benefits

Benefits will continue to be provided for dental services provided to a patient who is totally disabled when coverage ends, if:

1) The Dentist recommends the services to the patient in writing, and the services began, while coverage was in effect.
2) The services are not for routine examinations, prophylaxis, x-rays, sealants, or orthodontic services.
3) The services are provided within 90 days after the patient's coverage ended, and the coverage did not end because the patient (or, in the case of a dependent child, the child's parent) voluntarily terminated coverage.

The extension of Benefits ends at the earlier of:

1) the end of the 90-day period in 3) above; or
2) the date the patient becomes covered under a succeeding policy.

However, if coverage for the dental services described in this *Extension of Benefits* provision are excluded by the succeeding policy through the use of an elimination period or limitations and the patient is not covered by the succeeding policy, the extension of Benefits does not terminate.

All contractual limitations, exclusions or reductions that would have applied to the specific dental services had this coverage not terminated apply during the extension of Benefits.

Conversion

Any Eligible Dependent who has been continuously enrolled in this Program for at least 3 months immediately prior to termination is eligible for a conversion Contract providing Benefits similar to the terminated Contract. A person electing to convert to his or her own individual coverage must pay Premium to Delta Dental at individual rates established by Delta Dental. This provision will not apply if coverage is terminated due to (a) failure to pay any required Premium, (b) replacement of discontinued coverage within 31 days, (c) fraud or material misrepresentation in applying for or obtaining Benefits, (d) misuse of Benefits, (e) moving out of the DeltaCare USA service area or (f) uncooperative or abusive behavior toward the Contract Dentist's and/or Delta Dental's staff.

Entire Contract

This Contract, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement governing the Program. No amendment is valid unless approved by an executive officer of Delta Dental and attached to this booklet. No agent or broker has authority to amend this Contract or waive any of its provisions.

Governing Law

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the State of Florida is hereby amended to conform to the minimum requirements of such statutes.

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

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 -** ***When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." ****	
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

Code	Description	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)*	$5.00

D1000-D1999 II. PREVENTIVE - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

Code	Description	Cost
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	$25.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	$25.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 per 6 month period*	$20.00
D1208	Topical application of fluoride - *child to age 19; 1 per 6 month period*	$20.00
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$15.00
D1510	Space maintainer - fixed - unilateral	$100.00
D1515	Space maintainer - fixed - bilateral	$140.00
D1520	Space maintainer - removable - unilateral	$100.00
D1525	Space maintainer - removable - bilateral	$140.00
D1550	Re-cementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

D2000-D2999 III. RESTORATIVE - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

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

Code	Description	Cost
D2140	Amalgam - one surface, primary or permanent	$32.00
D2150	Amalgam - two surfaces, primary or permanent	$40.00
D2160	Amalgam - three surfaces, primary or permanent	$50.00
D2161	Amalgam - four or more surfaces, primary or permanent	$60.00

D2330	Resin-based composite - one surface, anterior (*tooth colored*)	$45.00
D2331	Resin-based composite - two surfaces, anterior (*tooth colored*)	$55.00
D2332	Resin-based composite - three surfaces, anterior (*tooth colored*)	$65.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (*tooth colored*)	$95.00
D2390	Resin-based composite crown, anterior	$95.00
D2391	Resin-based composite - one surface, posterior (*tooth colored*)	$75.00
D2392	Resin-based composite - two surfaces, posterior (*tooth colored*)	$85.00
D2393	Resin-based composite - three surfaces, posterior (*tooth colored*)	$100.00
D2394	Resin-based composite - four or more surfaces, posterior (*tooth colored*)	$110.00
D2510	Inlay - metallic - one surface [1, 2]	$260.00
D2520	Inlay - metallic - two surfaces [1, 2]	$270.00
D2530	Inlay - metallic - three or more surfaces [1, 2]	$280.00
D2542	Onlay - metallic - two surfaces [1, 2]	$270.00
D2543	Onlay - metallic - three surfaces [1, 2]	$290.00
D2544	Onlay - metallic - four or more surfaces [1, 2]	$300.00
D2610	Inlay - porcelain/ceramic - one surface [1, 3]	$340.00
D2620	Inlay - porcelain/ceramic - two surfaces [1, 3]	$360.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [1, 3]	$375.00
D2642	Onlay - porcelain/ceramic - two surfaces [1, 3]	$375.00
D2643	Onlay - porcelain/ceramic - three surfaces [1, 3]	$395.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [1, 3]	$420.00
D2650	Inlay - resin-based composite - one surface (*tooth colored*) [1, 3]	$230.00
D2651	Inlay - resin-based composite - two surfaces (*tooth colored*) [1, 3]	$270.00
D2652	Inlay - resin-based composite - three or more surfaces (*tooth colored*) [1, 3]	$300.00
D2662	Onlay - resin-based composite - two surfaces (*tooth colored*) [1, 3]	$310.00
D2663	Onlay - resin-based composite - three surfaces (*tooth colored*) [1, 3]	$325.00
D2664	Onlay - resin-based composite - four or more surfaces (*tooth colored*) [1, 3]	$355.00
D2710	Crown - resin-based composite (indirect) [1, 3]	$125.00
D2712	Crown - ¾ resin-based composite (indirect) [1, 3]	$125.00
D2720	Crown - resin with high noble metal [1, 3]	$425.00
D2721	Crown - resin with predominantly base metal [1, 3]	$325.00
D2722	Crown - resin with noble metal [1, 3]	$325.00
D2740	Crown - porcelain/ceramic substrate [1, 3]	$425.00
D2750	Crown - porcelain fused to high noble metal [1, 3]	$425.00
D2751	Crown - porcelain fused to predominantly base metal [1, 3]	$325.00
D2752	Crown - porcelain fused to noble metal [1, 3]	$325.00
D2780	Crown - ¾ cast high noble metal [1]	$425.00
D2781	Crown - ¾ cast predominantly base metal [1]	$325.00

D2782	Crown - ¾ cast noble metal [1]	$325.00
D2790	Crown - full cast high noble metal [1]	$425.00
D2791	Crown - full cast predominantly base metal [1]	$325.00
D2792	Crown - full cast noble metal [1]	$325.00
D2794	Crown - titanium [1]	$425.00
D2910	Recement inlay, onlay or partial coverage restoration	$20.00
D2915	Recement cast or prefabricated post and core	$20.00
D2920	Recement crown	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior) (tooth colored)*	$95.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior primary tooth*	$95.00
D2930	Prefabricated stainless steel crown - primary tooth	$80.00
D2931	Prefabricated stainless steel crown - permanent tooth	$80.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$95.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$95.00
D2940	Protective restoration	$20.00
D2941	Interim therapeutic restoration - primary dentition	$20.00
D2949	Restorative foundation for an indirect restoration	$65.00
D2950	Core buildup, including any pins when required	$65.00
D2951	Pin retention - per tooth, in addition to restoration	$25.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [2]	$110.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [2]	$50.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$85.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$45.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$35.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$65.00
D2980	Crown repair necessitated by restorative material failure	$50.00
D2981	Inlay repair necessitated by restorative material failure	$50.00
D2982	Onlay repair necessitated by restorative material failure	$50.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$15.00

D3000-D3999 IV. ENDODONTICS - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

D3110	Pulp cap - direct (excluding final restoration)	$25.00
D3120	Pulp cap - indirect (excluding final restoration)	$25.00

Code	Description	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$45.00
D3221	Pulpal debridement, primary and permanent teeth	$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$45.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [4]	$180.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) [4]	$230.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration) [4]	$375.00
D3346	Retreatment of previous root canal therapy - anterior [4]	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid [4]	$330.00
D3348	Retreatment of previous root canal therapy - molar [4]	$475.00
D3410	Apicoectomy - anterior [4]	$270.00
D3421	Apicoectomy - bicuspid (first root) [4]	$335.00
D3425	Apicoectomy - molar (first root) [4]	$380.00
D3426	Apicoectomy (each additional root) [4]	$105.00
D3427	Periradicular surgery without apicoectomy	$270.00
D3430	Retrograde filling - per root [4]	$65.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [4]	$315.00

**D4000-D4999 V. PERIODONTICS - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

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

Code	Description	Fee
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$650.00

D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$650.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$80.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$80.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$80.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$50.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [5, 6]	$450.00
D5120	Complete denture - mandibular [5, 6]	$450.00
D5130	Immediate denture - maxillary [5, 6]	$550.00
D5140	Immediate denture - mandibular [5, 6]	$550.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [5, 6]	$300.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [5, 6]	$300.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [5, 6]	$550.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [5, 6]	$550.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [5, 6]	$600.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [5, 6]	$600.00
D5410	Adjust complete denture - maxillary [5]	$20.00
D5411	Adjust complete denture - mandibular [5]	$20.00
D5421	Adjust partial denture - maxillary [5]	$20.00
D5422	Adjust partial denture - mandibular [5]	$20.00
D5510	Repair broken complete denture base	$50.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$25.00
D5610	Repair resin denture base	$55.00
D5620	Repair cast framework	$55.00
D5630	Repair or replace broken clasp	$55.00
D5640	Replace broken teeth - per tooth	$25.00
D5650	Add tooth to existing partial denture	$55.00
D5660	Add clasp to existing partial denture	$55.00

D5710	Rebase complete maxillary denture [7]	$130.00
D5711	Rebase complete mandibular denture [7]	$130.00
D5720	Rebase maxillary partial denture [7]	$130.00
D5721	Rebase mandibular partial denture [7]	$130.00
D5730	Reline complete maxillary denture (chairside) [7]	$50.00
D5731	Reline complete mandibular denture (chairside) [7]	$50.00
D5740	Reline maxillary partial denture (chairside) [7]	$45.00
D5741	Reline mandibular partial denture (chairside) [7]	$45.00
D5750	Reline complete maxillary denture (laboratory) [7]	$150.00
D5751	Reline complete mandibular denture (laboratory) [7]	$150.00
D5760	Reline maxillary partial denture (laboratory) [7]	$150.00
D5761	Reline mandibular partial denture (laboratory) [7]	$150.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [5]	$55.00
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [5]	$55.00
D5850	Tissue conditioning, maxillary [5, 7]	$30.00
D5851	Tissue conditioning, mandibular [5, 7]	$30.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

D6210	Pontic - cast high noble metal [8]	$425.00
D6211	Pontic - cast predominantly base metal [8]	$325.00
D6212	Pontic - cast noble metal [8]	$325.00
D6240	Pontic - porcelain fused to high noble metal [3, 8]	$425.00
D6241	Pontic - porcelain fused to predominantly base metal [3, 8]	$325.00
D6242	Pontic - porcelain fused to noble metal [3, 8]	$325.00
D6245	Pontic - porcelain/ceramic [3, 8]	$425.00
D6250	Pontic - resin with high noble metal [3, 8]	$425.00
D6251	Pontic - resin with predominantly base metal [3, 8]	$325.00
D6252	Pontic - resin with noble metal [3, 8]	$325.00
D6600	Inlay - porcelain/ceramic, two surfaces [3, 8]	$360.00
D6601	Inlay - porcelain/ceramic, three or more surfaces [3, 8]	$375.00
D6602	Inlay - cast high noble metal, two surfaces [2, 8]	$270.00
D6603	Inlay - cast high noble metal, three or more surfaces [2, 8]	$280.00
D6604	Inlay - cast predominantly base metal, two surfaces [8]	$270.00
D6605	Inlay - cast predominantly base metal, three or more surfaces [8]	$280.00
D6606	Inlay - cast noble metal, two surfaces [8]	$270.00

D6607 Inlay - cast noble metal, three or more surfaces [8] $280.00
D6608 Onlay - porcelain/ceramic, two surfaces [3, 8] $375.00
D6609 Onlay - porcelain/ceramic, three or more surfaces [3, 8] $395.00
D6610 Onlay - cast high noble metal, two surfaces [2, 8] $270.00
D6611 Onlay - cast high noble metal, three or more surfaces [2, 8] $290.00
D6612 Onlay - cast predominantly base metal, two surfaces [8] $270.00
D6613 Onlay - cast predominantly base metal, three or more surfaces [8] .. $290.00
D6614 Onlay - cast noble metal, two surfaces [8] $270.00
D6615 Onlay - cast noble metal, three or more surfaces [8] $290.00
D6720 Crown - resin with high noble metal [3, 8] $425.00
D6721 Crown - resin with predominantly base metal [3, 8] $325.00
D6722 Crown - resin with noble metal [3, 8] $325.00
D6740 Crown - porcelain/ceramic [3, 8] $425.00
D6750 Crown - porcelain fused to high noble metal [3, 8] $425.00
D6751 Crown - porcelain fused to predominantly base metal [3, 8] $325.00
D6752 Crown - porcelain fused to noble metal [3, 8] $325.00
D6780 Crown - ¾ cast high noble metal [8] $425.00
D6781 Crown - ¾ cast predominantly base metal [8] $325.00
D6782 Crown - ¾ cast noble metal [8] $325.00
D6790 Crown - full cast high noble metal [8] $425.00
D6791 Crown - full cast predominantly base metal [8] $325.00
D6792 Crown - full cast noble metal [8] $325.00
D6930 Recement fixed partial denture $30.00
D6940 Stress breaker [8] $50.00
D6980 Fixed partial denture repair necessitated by restorative material failure $75.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - ***When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." ****

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

D7111 Extraction, coronal remnants - deciduous tooth $40.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) $40.00
D7210 Surgical removal of erupted tooth requiring removal of bone and/ or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated $70.00
D7220 Removal of impacted tooth - soft tissue $95.00
D7230 Removal of impacted tooth - partially bony $190.00
D7240 Removal of impacted tooth - completely bony $210.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications $230.00
D7250 Surgical removal of residual tooth roots (cutting procedure) $75.00

D7251	Coronectomy - intentional partial tooth removal	$230.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$100.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$150.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$150.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$200.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$200.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$35.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$160.00

D8000-D8999 XI. ORTHODONTICS

*** If a Copayment dollar amount is not listed, Enrollee pays 75 percent of the Contract Orthodontist's "filed fees."*

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [9]	**
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [9]	**
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children from age 19 to 25* [9]	**
D8660	Pre-orthodontic treatment visit - *not to be charged with any other consultation procedure(s)* [10]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) [11]	**
D8999	Unspecified orthodontic procedure, by report - *includes START-UP FEES, (including initial examination, diagnosis, consultation and initial banding)*	$200.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$35.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$70.00

Code	Procedure	Copayment
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$50.00
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*	$15.00

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 Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

* If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed referable procedures, that are not available in the contract facility or that require a Dentist to provide specialized services, may be provided by a contracted oral surgeon, endodontist, periodontist or pediatric dentist at 75 percent of the Contract Specialist's "filed fees." Specialist services are only available in areas where there is a DeltaCare USA Contract Specialist, and upon referral by the assigned Contract Dentist.

FOOTNOTES

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

2. *Base or noble metal is the benefit. If an 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.*

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

4. *A benefit for permanent teeth only.*

5. *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.*

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

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

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

9 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee), and D8680 (Orthodontic retention). Beyond 24 months, an additional monthly fee not to exceed 75 percent of the Contract Orthodontist's "filed fee" applies.*

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

11 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee not to exceed 75 percent of the Contract Orthodontist's "filed fee" applies.*

SCHEDULE B

Limitations of Benefits

1. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months.
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. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
5. 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 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.
6. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
7. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling. Replacement of an existing crown, inlay or onlay that is non-functional or non-restorable is a benefit when the existing restoration is five+ years old.
8. 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.
9. A covered metallic inlay, onlay, or indirectly fabricated post and core 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.
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. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.

12. 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 with pathology.
13. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
14. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
16. Coverage for the placement of a fixed partial denture ("bridge") is limited to:
    a. The initial placement of a bridge when all the following conditions are present:
        - a single permanent tooth requires prosthetic replacement.
        - the abutment teeth can adequately support and retain a new bridge.
        - the missing tooth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture.
        - no other missing teeth in the same arch require prosthetic replacement with a new removable partial denture; and (*for a bridge replacing a posterior tooth*) one or more of the abutment teeth meet Limitation #7.
    b. The replacement of an existing bridge that is not serviceable due to decay, fracture or other non-cosmetic defect, if:
        - the existing bridge is at least five years old; **and**
        - the same abutment teeth can adequately support and retain a new bridge; **and**
        - no other missing teeth in the same arch require prosthetic replacement.
17. Coverage for a new removable partial or complete denture is limited to:
    a. The initial placement of removable partial or complete denture in an arch when:
        - one or more permanent teeth require prosthetic replacement; **and**
        - the missing tooth/teeth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture; **and**
        - (for partial dentures only) there are suitable abutment teeth to retain and support a removable partial denture.
    b. The replacement of an existing removable partial or complete denture with non-cosmetic defect(s) that cause the denture to be non-serviceable if:
        - the existing removable denture is at least five years old; **and**
        - the existing removable denture cannot be made serviceable by adjustment, repair, relining or rebasing.
18. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.

19. 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.
20. 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.
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 contracted pediatric Dentist are available at 75 percent of the Contract Specialist's "filed fees." Referral by the assigned Contract Dentist is required before services are received.
24. 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.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. 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).
6. 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.
7. 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.
8. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
9. Extraction/removal of an erupted, partially erupted or impacted tooth:
    a. Solely for orthodontic purposes.
    b. When the tooth exhibits no signs or symptoms of infection, cystic degeneration, fracture, caries and/or having caused damage to an adjacent tooth; **or**
    c. When the extraction or removal would be inconsistent with generally accepted professional standards.
10. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
11. Consultations for non-covered benefits.
12. Replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or better match bleached teeth.

13. Dental services received from any dental facility other than the assigned Contract Dentist including the services of an out-of-network dental specialist, unless expressly authorized by Delta Dental or as cited under *Emergency Services*.
14. 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.
15. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
16. 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.
17. Dispensing of drugs not normally utilized in the delivery of dental services.
18. 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.
19. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
20. Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is paid. Services that 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.
21. Treatment required by reason of war, declared or undeclared.
22. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
23. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Orthodontic Limitations

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

1. Orthodontic treatment must be provided by the selected Contract Orthodontist.
2. Orthodontic Copayments are listed on *Schedule A*, for comprehensive orthodontic treatment. Additional fees will be charged for start-up and retention.
3. Benefits cover 24 months of active comprehensive orthodontic treatment, including initial banding, de-banding and any commonly used appliances such as headgear.
4. Following benefited comprehensive orthodontic treatment, retention is covered up to a maximum of 24 months. Retention includes the initial construction, placement and adjustment to removable retainers and office visits.
5. Treatment plans extending beyond 24 months of active comprehensive orthodontic treatment, or 24 months of retention, will be subject to a monthly office visit fee to the Enrollee not to exceed 75 percent of the Contract Orthodontist's "filed fees" per month.
6. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall increase to a maximum of the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.
7. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $85.00 in addition to diagnostic record fees.
8. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee.

9. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
   a. will not be entitled to a refund of any amounts previously paid; **and**
   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
10. Coverage and treatment under this Program are conditioned on patients following the treatment plan recommended by their Contract Orthodontist. Failure to follow the instructions of the Contract Orthodontist can compromise the health of teeth and/or gums, which may necessitate discontinuation of treatment. Patients who are required to restart their orthodontic treatment because of non-compliance with the treatment plan will be subject again to all applicable Copayments.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records that include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.
4. Surgical procedures incidental to orthodontic treatment.
5. Myofunctional therapy.
6. Surgical procedures related to cleft palate, micrognathia or macrognathia.
7. Treatment related to temporomandibular joint disturbances.
8. Supplemental appliances not routinely used in comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.
9. Restorative work caused by orthodontic treatment.
10. 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.
11. Extractions solely for the purpose of orthodontics.
12. Treatment in progress at inception of eligibility.
13. Patient initiated transfer after bands have been placed.
14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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

- Toll Free
  800-422-4234

or write the Program Administrator at:

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

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