DeltaCare® USA
Senior Dental Program

Disclosure Form/Contract

Provided by:

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703-8579
800-422-4234
wekeepyousmiling.com

DISCLOSURE FORM/CONTRACT

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

Delta Dental of California
("Delta Dental")
12898 Towne Center Drive
Cerritos, CA 90703

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

Persons with special health care needs should read completely and carefully the section entitled "Special Needs".

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 SPECIALTY SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST. A matrix describing the Program's major Benefits and coverage appears after the Enrollment and Payment Authorization Form.

ADDITIONAL INFORMATION ABOUT YOUR BENEFITS IS AVAILABLE BY CALLING THE CUSTOMER SERVICE DEPARTMENT AT 800-422-4234, 5 a.m. - 6 p.m. PACIFIC TIME, MONDAY THROUGH FRIDAY.

A STATEMENT DESCRIBING DELTA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

DeltaCare® USA

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703-8579

Check One **Broker #:** _____

- ❑ New Enrollment
- ❑ Name Change

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

Month ____ Day ____ Year ____

DeltaCare USA SENIOR PROGRAM
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Applicant Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY - (PLEASE LEAVE ONE BLANK BOX BETWEEN EACH WORD)

Name: Last _____ First _____ MI _____

Mailing Address: Street Address _____

City _____ State _____ Zip Code _____

Date of Birth: Month ____ Day ____ Year ____

Male ❑ Female ❑

Home Phone #: (____) ____ — ____

Identification #: ____ — ____ — ____

Contract Facility Name: _____

Contract Facility #: _____

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dental's ratio of health care expenses to premiums received for the last calendar year, with respect to the DeltaCare USA Senior Dental HMO Program, was **58.5%**.

Return form to Delta Dental of California at Dept. 0170, Los Angeles, CA 90084-0170

Signature of Applicant: _____ Date: _____

DeltaCare® USA

PLEASE PRINT LEGIBLY

Please complete both forms

PROGRAM COST

Choose one based on the information on the reverse side.

❑	Enrollee Premium	**$ 135.00**
❑	One-time Enrollment Fee	**$ 15.00**
	TOTAL	**$ 150.00**

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 Senior Dental HMO 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.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

PAYMENT OPTION (choose only one)

PAYMENT OPTIONS

❑ CHECK/MONEY ORDER PAYMENT OPTION
Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

❑ 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 Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

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

Signature: _____ Date: _____

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Information Concerning Benefits Under The DeltaCare USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS DISCLOSURE FORM/CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the *Description of Benefits and Copayments*, subject to the *Limitations and Exclusions* of the program. Copayments range by category of service. Examples are as follows: Diagnostic Services No Cost-$ 5.00 Preventive Services No Cost-$150.00 Restorative Services No Cost-$425.00 Endodontic Services No Cost-$475.00 Periodontic Services $ 45.00-$450.00 Prosthodontic Services Removable $ 20.00-$495.00 Prosthodontic Services Fixed $ 20.00-$425.00 Oral and Maxillofacial Surgery $ 35.00-$150.00 Adjunctive General Services No Cost-$ 50.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified providers, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to once in each six month period; replacement of removable and fixed dentures and crowns is limited to once in any five year period.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $100 per emergency for out-of-area emergency services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and which is covered under the Program has a specific Copayment, which is shown in the *Description of Benefits and Copayments*, in this Disclosure Form/Contract.

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Definitions

As used in this Disclosure Form/Contract:

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

Benefits mean those dental services which 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 Specialist means a Dentist who provides Specialist Services, and who has agreed to provide Benefits to Enrollees under this Program.

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

Copayment means the amounts shown on *Schedule A* which an Enrollee pays directly to a Dentist for Benefits.

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.

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

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i) placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Enrollee means a person enrolled to receive Benefits under this Program.

Optional means 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 Contract.

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

Premium means the amount payable as provided in this Disclosure Form/Contract.

Special Health Care Need means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics or periodontics and which must be preauthorized in writing by Delta Dental.

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

We, Us or Our means Delta Dental of California.

What is the DeltaCare USA Senior Dental HMO Program ("Program")?

The DeltaCare USA Senior Dental HMO Program offered by Delta Dental provides comprehensive dental care through a convenient network of Contract Dentists in the State of California. 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 covered Benefits. There are no deductibles, lifetime maximums or claim forms under this Program.

Who is eligible for coverage?

Individual adults are eligible for coverage under the DeltaCare USA Senior Dental HMO Program. Dependent coverage is not available under this Program.

How do I enroll?

First, please read all the information contained in this Disclosure Form/Contract (particularly the Schedule 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 your treatment. Third, complete the *Enrollment and Payment Authorization Form* and indicate which contract facility you have chosen.

How much do I pay?

The annual Premium for the initial Contract Term is:

*	Enrollee only (one person):	$135.00
	plus a one-time enrollment fee of $15.00	

Choose a Payment Option

For your convenience, Delta Dental has made it possible to choose from two payment options. The 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 on the *Enrollment and Payment Authorization Form*.

* **Credit Card Payment Option**
  If you choose the Credit Card Payment 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 prefer to pay by personal check or money order, select that option on the *Enrollment and Payment Authorization Form* and make your check payable to Delta Dental of California.

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 of California
Dept. 0170
Los Angeles, CA 90084-0170

What will my Effective Date be?

Delta Dental must receive the enrollment materials by the 21st day of the month for coverage to be effective the first day of the following month. If we receive the enrollment materials after the 21st day of the month, coverage will become effective the first day of the second month.

How to use the DeltaCare USA Program - Choice of Contract Dentist

When you enroll in the Program, you will select a Contract Dentist from the list of dental facilities included with this Disclosure Form/Contract. You must indicate the Contract Dentist's name and facility ID# on the *Enrollment and Payment Authorization Form* (attached to this Disclosure Form/Contract).

Shortly after enrollment, you will receive a DeltaCare USA membership packet which advises you of the Effective Date of your Program and the address and telephone number of your Contract Dentist. You may obtain covered dental services any time after the Effective Date stated in your membership packet. Simply call your Contract Dentist to make an appointment and identify yourself as an Enrollee in the DeltaCare USA Program. Your assigned Contract Dentist also maintains a 24-hour Emergency Services system seven days a week. Inquiries regarding availability of appointments and accessibility of Contract Dentists should be directed to the Customer Service department at (800) 422-4234.

YOU MUST GO TO YOUR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES EXCEPT FOR SPECIALIST SERVICES AUTHORIZED IN WRITING BY DELTA DENTAL OR FOR EMERGENCY SERVICES.

TREATMENT PROVIDED BY AN OUT-OF-NETWORK DENTIST IS NOT COVERED UNDER THIS PROGRAM UNLESS PREAUTHORIZED BY US.

Emergency Services

The Contract Dentist will provide Emergency Services for covered dental 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.

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

Specialist Services

Treatment for covered procedures which requires a Dentist to provide Specialist Services for oral surgery, endodontics or periodontics must be (1) referred by the assigned Contract Dentist, and (2) preauthorized in writing by us. You pay the specified Copayment. (Refer to *Schedule A*.)

IF YOU REQUIRE SPECIALIZED SERVICES AND THERE IS NO CONTRACT DENTIST TO PROVIDE THESE SERVICES WITHIN 35 MILES OF YOUR HOME ADDRESS, YOUR ASSIGNED CONTRACT DENTIST MUST RECEIVE WRITTEN PREAUTHORIZATION FROM DELTA DENTAL TO REFER YOU TO AN OUT-OF-NETWORK DENTIST TO PROVIDE THE SPECIALIZED SERVICES. SPECIALIST SERVICES PERFORMED BY AN OUT-OF-NETWORK DENTIST THAT ARE NOT PREAUTHORIZED BY DELTA DENTAL MAY NOT BE COVERED.

If you are referred to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor. Services provided by a health care professional not listed within this section are not covered.

Special Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service department at (800) 422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist you in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Dental Facility Accessibility

Many dental facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, contact Delta Dental's Customer Service department at (800) 422-4234.

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 (wekeepyousmiling.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. If a facility is closed to further enrollment, or if a Contract Dentist withdraws from the Program, we will provide you written notice and assign you to a Contract Dentist facility nearest your home.

All treatment in progress such as 1) partial or full dentures for which final impressions have been taken, 2) completion of root canals and 3) delivery of crowns when teeth have been prepared, must be completed before you change to another Contract facility.

If your assigned Contract Dentist terminates participation in this Program, that Contract Dentist will complete 1) a partial or full denture for which final impressions have been taken, and 2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared) under the terms of this Program.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in *Schedule A* subject to the Limitations and Exclusions described in *Schedule B*. The services are performed as needed and deemed necessary by your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A* 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. By statute, every contract between Delta Dental and our Contract Dentists contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental.

If you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Provider Compensation

A Contract Dentist is compensated by Delta Dental through monthly fees based on the number of Enrollees assigned to the Contract Dentist, and by Enrollees through required Copayments for treatment received. Contract Specialists are compensated by Enrollees through required Copayments for treatment received. **In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.**

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this Disclosure Form/Contract.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that an Enrollee obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving cases of imminent and serious health threat will be expedited with authorization approved or denied within 72 hours of receipt of the request, whenever possible. For assistance or additional information regarding the procedures and time frames for second opinion authorizations, you should contact Delta Dental's Customer Service department at (800) 422-4234 or write to the address on the back of this booklet. Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Delta Dental's dental consultant. Delta Dental will pay only for a second opinion which Delta Dental has approved or authorized.

Claims for Reimbursement

Claims for covered Emergency Dental Services or covered Specialized Services must be submitted to us within 90 days of completion 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 and the claim is submitted as soon as possible. However, all claims must be received within one year of the treatment date.

Processing Policies

Delta Dental does not authorize or deny services provided by your assigned Contract Dentist. All Benefits provided by your assigned Contract Dentist are in accordance with dental care guidelines which establish the standard of care to be followed by Contract Dentists. Delta Dental's processing policies and the dental care guidelines are reviewed by Delta Dental's dental advisory committee and updated as needed. You may contact Delta Dental's Customer Service department at (800) 422-4234 for information regarding Delta Dental's processing policies and dental care guidelines.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies,

procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call Delta Dental's Customer Service department at (800) 422-4234, or the complaint may be addressed in writing to:

Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, CA 90703-8579

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

Within 5 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 422-4234** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

IMR has limited application to your dental program. You may request an IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

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 30 days before your coverage expires. Your coverage will terminate at the end of the Contract Term unless you renew by paying the applicable Premium on or before the expiration date of your Contract.

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.

Enrollment will be cancelled by Delta Dental in the following events:

1) Immediately, if Delta Dental determines that the Enrollee is guilty of misconduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if the Enrollee knowingly perpetrates or permits another person to perpetrate fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if the Enrollee fails to pay Copayments; provided, however, that the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges;
4) Upon 30 days written notice upon failure of an Enrollee and a Contract Dentist to establish a satisfactory patient-dentist relationship if it is shown that Delta Dental has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist, and the Enrollee has been notified in writing at least 30 days in advance that Delta Dental considers the patient-dentist relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid cancellation, and the Enrollee has failed to make such changes.

If we cancel your coverage for any other reason or if you cancel coverage by giving us 30 days' advance written notice because a) no Contract Dentist is available to you, b) you move out of the DeltaCare USA service area, or c) you change to coverage under a group program, Delta Dental will, within 30 days, return to you the pro rata portion of the Premium paid for any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to us. **Otherwise, no refunds will be made.**

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). Any cancellation is subject to the written notification requirements set forth in this booklet.

An Enrollee who believes that enrollment has been cancelled or not renewed because of dental condition or the need for dental care may request a review of the cancellation by the Director of the Department of Managed Health Care of the State of California.

Entire Contract

This Disclosure Form/Contract, and any attached schedules, appendices, endorsements and riders to the Contract, 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.

Standing Committee on Public Policy

A six member committee, comprised of one Dentist, four representatives from the purchaser and subscriber community and one member of the Delta Dental Board of Directors, meets quarterly and participates in establishing policies to assure the comfort, dignity, and convenience of Enrollees and the public. Issues may be presented to this committee by writing to Delta Dental's Public Policy Committee, c/o Professional Relations, at the address on the back of this Disclosure Form/Contract.

Governing Law

This Program is a health care service plan subject to the requirements of Chapter 22 of Division 2 of the California Health & Safety Code and Chapter 1 of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be included in this Disclosure Form/Contract by the above law and regulation binds this Program whether or not stated.

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. Delta Dental agrees 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-2007 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic film	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

D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	$20.00
D1330	Oral hygiene instructions	No Cost
D1510	Space maintainer - fixed - unilateral	$100.00
D1515	Space maintainer - fixed - bilateral	$150.00
D1520	Space maintainer - removable - unilateral	$100.00
D1525	Space maintainer - removable - bilateral	$150.00
D1550	Re-cementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

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	$27.00
D2150	Amalgam - two surfaces, primary or permanent	$32.00
D2160	Amalgam - three surfaces, primary or permanent	$37.00
D2161	Amalgam - four or more surfaces, primary or permanent	$50.00
D2330	Resin-based composite - one surface, anterior (*tooth colored*)	$55.00
D2331	Resin-based composite - two surfaces, anterior (*tooth colored*)	$65.00
D2332	Resin-based composite - three surfaces, anterior (*tooth colored*)	$75.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (*tooth colored*)	$85.00
D2390	Resin-based composite crown, anterior	$85.00
D2391	Resin-based composite - one surface, posterior (*tooth colored*)	$75.00
D2392	Resin-based composite - two surfaces, posterior (*tooth colored*)	$80.00
D2393	Resin-based composite - three surfaces, posterior (*tooth colored*)	$85.00
D2394	Resin-based composite - four or more surfaces, posterior (*tooth colored*)	$95.00
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]	$360.00
D2620	Inlay - porcelain/ceramic - two surfaces [1]	$370.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [1]	$380.00
D2642	Onlay - porcelain/ceramic - two surfaces [1]	$370.00
D2643	Onlay - porcelain/ceramic - three surfaces [1]	$390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [1]	$400.00
D2650	Inlay - resin-based composite - one surface (*tooth colored*) [1]	$260.00
D2651	Inlay - resin-based composite - two surfaces (*tooth colored*) [1]	$270.00
D2652	Inlay - resin-based composite - three or more surfaces (*tooth colored*) [1]	$280.00
D2662	Onlay - resin-based composite - two surfaces (*tooth colored*) [1]	$270.00
D2663	Onlay - resin-based composite - three surfaces (*tooth colored*) [1]	$280.00
D2664	Onlay - resin-based composite - four or more surfaces (*tooth colored*) [1]	$300.00
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
D2931	Prefabricated stainless steel crown - permanent tooth	$80.00
D2940	Sedative filling	$20.00
D2950	Core buildup, including any pins	$50.00
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]	$95.00
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*	$70.00
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, by report	$50.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$25.00
D3120	Pulp cap - indirect (excluding final restoration)	$25.00
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	$45.00
D3310	*Root canal* - anterior (excluding final restoration)	$180.00
D3320	*Root canal* - bicuspid (excluding final restoration)	$230.00
D3330	*Root canal* - molar (excluding final restoration)	$375.00
D3346	Retreatment of previous root canal therapy - anterior	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid	$330.00
D3348	Retreatment of previous root canal therapy - molar	$475.00
D3410	Apicoectomy/periradicular surgery - anterior	$270.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$335.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$380.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$105.00
D3430	Retrograde filling - per root	$50.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection*	$75.00

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 bounded teeth spaces per quadrant	$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$300.00

D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$300.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$450.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$450.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$60.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$45.00

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [4, 5]	$395.00
D5120	Complete denture - mandibular [4, 5]	$395.00
D5130	Immediate denture - maxillary [4, 5]	$495.00
D5140	Immediate denture - mandibular [4, 5]	$495.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [4, 5]	$300.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [4, 5]	$300.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [4, 5]	$425.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [4, 5]	$425.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [4, 5]	$475.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [4, 5]	$475.00
D5410	Adjust complete denture - maxillary [4]	$20.00
D5411	Adjust complete denture - mandibular [4]	$20.00
D5421	Adjust partial denture - maxillary [4]	$20.00
D5422	Adjust partial denture - mandibular [4]	$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	$50.00
D5620	Repair cast framework	$90.00
D5630	Repair or replace broken clasp	$45.00
D5640	Replace broken teeth - per tooth	$25.00
D5650	Add tooth to existing partial denture	$45.00
D5660	Add clasp to existing partial denture	$45.00
D5710	Rebase complete maxillary denture [6]	$130.00
D5711	Rebase complete mandibular denture [6]	$130.00
D5720	Rebase maxillary partial denture [6]	$130.00
D5721	Rebase mandibular partial denture [6]	$130.00
D5730	Reline complete maxillary denture (chairside) [6]	$50.00
D5731	Reline complete mandibular denture (chairside) [6]	$50.00
D5740	Reline maxillary partial denture (chairside) [6]	$45.00
D5741	Reline mandibular partial denture (chairside) [6]	$45.00
D5750	Reline complete maxillary denture (laboratory) [6]	$150.00
D5751	Reline complete mandibular denture (laboratory) [6]	$150.00
D5760	Reline maxillary partial denture (laboratory) [6]	$150.00
D5761	Reline mandibular partial denture (laboratory) [6]	$150.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [4]	$55.00
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [4]	$55.00
D5850	Tissue conditioning, maxillary [4, 6]	$30.00
D5851	Tissue conditioning, mandibular [4, 6]	$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 [7]	$425.00
D6211	Pontic - cast predominantly base metal [7]	$325.00
D6212	Pontic - cast noble metal [7]	$325.00
D6240	Pontic - porcelain fused to high noble metal [3, 7]	$425.00
D6241	Pontic - porcelain fused to predominantly base metal [3, 7]	$325.00
D6242	Pontic - porcelain fused to noble metal [3, 7]	$325.00
D6245	Pontic - porcelain/ceramic [3, 7]	$425.00
D6250	Pontic - resin with high noble metal [3, 7]	$425.00
D6251	Pontic - resin with predominantly base metal [3, 7]	$325.00

D6252	Pontic - resin with noble metal [3, 7]	$325.00
D6600	Inlay - porcelain/ceramic, two surfaces [7]	$425.00
D6601	Inlay - porcelain/ceramic, three or more surfaces [7]	$425.00
D6602	Inlay - cast high noble metal, two surfaces [2, 7]	$270.00
D6603	Inlay - cast high noble metal, three or more surfaces [2, 7]	$280.00
D6604	Inlay - cast predominantly base metal, two surfaces [7]	$270.00
D6605	Inlay - cast predominantly base metal, three or more surfaces [7]	$280.00
D6606	Inlay - cast noble metal, two surfaces [7]	$270.00
D6607	Inlay - cast noble metal, three or more surfaces [7]	$280.00
D6608	Onlay - porcelain/ceramic, two surfaces [7]	$425.00
D6609	Onlay - porcelain/ceramic, three or more surfaces [7]	$425.00
D6610	Onlay - cast high noble metal, two surfaces [2, 7]	$270.00
D6611	Onlay - cast high noble metal, three or more surfaces [2, 7]	$290.00
D6612	Onlay - cast predominantly base metal, two surfaces [7]	$270.00
D6613	Onlay - cast predominantly base metal, three or more surfaces [7]	$290.00
D6614	Onlay - cast noble metal, two surfaces [7]	$270.00
D6615	Onlay - cast noble metal, three or more surfaces [7]	$290.00
D6720	Crown - resin with high noble metal [3, 7]	$425.00
D6721	Crown - resin with predominantly base metal [3, 7]	$325.00
D6722	Crown - resin with noble metal [3, 7]	$325.00
D6740	Crown - porcelain/ceramic [3, 7]	$425.00
D6750	Crown - porcelain fused to high noble metal [3, 7]	$425.00
D6751	Crown - porcelain fused to predominantly base metal [3, 7]	$325.00
D6752	Crown - porcelain fused to noble metal [3, 7]	$325.00
D6780	Crown - ¾ cast high noble metal [7]	$425.00
D6781	Crown - ¾ cast predominantly base metal [7]	$325.00
D6782	Crown - ¾ cast noble metal [7]	$325.00
D6790	Crown - full cast high noble metal [7]	$425.00
D6791	Crown - full cast predominantly base metal [7]	$325.00
D6792	Crown - full cast noble metal [7]	$325.00
D6930	Recement fixed partial denture	$30.00
D6940	Stress breaker [2, 7]	$50.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation* [2]	$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation*	$85.00
D6973	Core buildup for retainer, including any pins	$50.00
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [2]	$30.00

D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$20.00
D6980	Fixed partial denture repair, by report	$50.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	$35.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$65.00
D7220	Removal of impacted tooth - soft tissue	$75.00
D7230	Removal of impacted tooth - partially bony	$90.00
D7240	Removal of impacted tooth - completely bony	$130.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$65.00
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$70.00
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	$105.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$105.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$75.00

D8000-D8999 XI. ORTHODONTICS - Not Covered

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

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	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$35.00

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

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] *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] *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.*

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

[6] *Limited to 1 per denture during any 12 consecutive months.*

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

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. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
6. 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.
7. A covered metallic inlay, onlay, and indirectly fabricated post and core using base or noble metal is available for listed Copayment(s). If you elect to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
8. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If you elect to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
9. If you also choose a porcelain margin for a covered porcelain-fused to metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
10. 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.

11. 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.
12. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
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. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
17. 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.
18. 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.

19. Soft tissue management programs are limited to periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If you decline non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
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 you continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
21. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by you, and is subject to the limitations and exclusions of the Program. The applicable charge to you is the difference between the Contract Dentist's "filed fee" for the Optional procedure and 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 these fees should be directed to Delta Dental's Customer Service department at (800) 422-4234.

Exclusions of Benefits

1. All procedures not shown in *Schedule A*, *Description of Benefits and Copayments*.
2. Dental conditions arising out of and due to your employment for which Workers' Compensation is paid. Services that are provided to you by state government or agency thereof, or are provided without cost by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before your eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress.
7. Congenital malformations.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist or our dental consultant:
   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 preauthorized in writing by us or as cited under Emergency Services. To obtain written authorization, you should call the Customer Service department at (800) 422-4234.
11. Consultations for non-covered benefits.
12. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

14. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
15. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction 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 affect any other Benefits.
16. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
17. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
20. Treatment of retained primary teeth.
21. Specialist Services received from an orthodontist or pediatric dentist.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

If you have any questions or need additional information call:

Toll Free
800-422-4234

or write the Program Administrator at:

Delta Dental of California
12898 Towne Center Drive
Cerritos, CA 90703-8579

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