

Benefit highlights

DeltaCare® USA



DeltaCare USA¹ copayment plans give you easy dental care from a trusted in-network dentist that you choose.² You'll know what procedures are covered and how much each costs. No surprises.

Comprehensive coverage

- Coverage for 350+ procedures
- Regular preventive care with low or no copayments to help catch issues before more serious problems develop
- Covers standard dental materials at no extra cost, but choosing upgraded options like precious metal, titanium, or porcelain on back teeth will cost more
- Specialist services for oral surgery, endodontics, orthodontics, periodontics and pediatric dentistry

Budget-friendly

- No deductibles or maximums³ for covered services⁴

- Out-of-pocket costs listed in your Evidence of Coverage booklet, available in your online account
- Cleanings and exams covered with low or no copayments

Large network of quality dentists

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

Convenient services

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

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

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

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

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

⁴ State-specific exceptions may apply.

deltadentalins.com/universityoftexas

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

How DeltaCare USA works

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

- **You must visit** a DeltaCare USA general dentist to use your plan.¹
 - Dependent children under the age of 14 may obtain covered care from an in-network pediatric dentist without referral from a general dentist. Your general dentist will coordinate and refer you to specialists for care, if needed.
- **You may select** an in-network general dentist, or a general dentist can be assigned at first visit if you haven't selected a dentist yet.²
- **You can select** or change dentists anytime online or by phone.
- **Pay predefined copayments** shown in your plan booklet or online account at the time of service.
- **No deductibles, maximums or waiting periods** for covered services. No claims to submit — no hassle!

What your plan covers

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

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

Getting started

To enroll in a DeltaCare USA plan, simply complete the enrollment process as directed by your benefits administrator. Select a new DeltaCare USA dentist or check to see if your preferred general dentist is in-network.

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

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

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

General plan information

You and your eligible dependents have emergency dental service coverage for out-of-area emergencies when you are more than 35 miles from your selected general dentist.³ Your out-of-area emergency benefit (typically limited to \$100 per person) is for services to relieve pain until you can return to see your

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

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

³ Exceptions may apply. Refer to your Evidence/Certificate of Coverage.

We make it easy for you!



Receive your
welcome
materials



Visit your
DeltaCare USA
dentist



Receive
dental care



Pay only your
copayment

general dentist.⁴ Standard plan limitations, exclusions and copayments may apply.

There are no exclusions for most pre-existing conditions, except work in progress.⁵ Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

Glossary

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

Authorization: The process by which Delta Dental determines whether a procedure or treatment is a referable benefit under your plan. Your assigned general dentist must obtain prior authorization from us to refer you to an out-of-network specialist or out-of-network orthodontist. Services performed by an out-of-network dentist, specialist or orthodontist that are not authorized by us will not be covered.

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

DeltaCare USA dentist: A dentist who is a member of the DeltaCare USA network. These dentists have contracted with Delta Dental and

agreed to accept negotiated fees for the services provided to DeltaCare USA members. You must visit a DeltaCare USA dentist to receive plan benefits.

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

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

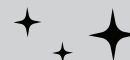
Limitations and Exclusions: Limitations are usually related to a specific time or frequency — for example, a plan may cover only two cleanings in a 12-month period or one cleaning every six months. Exclusions are services not covered by a plan.

(Dental) Referral: Directing a patient to a dental specialist by a general dentist. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.⁶

Specialist services: Services performed by a dental specialist, such as oral surgery, endodontics, periodontics or pediatric dentistry. When specialty dental care is needed, your general dentist will refer you to a trusted specialist in the network.⁶



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



⁴ In TX, there is no limit on the number of miles or on the dollar amount per emergency.

⁵ In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

⁶ Dependent children covered under a DeltaCare USA plan have the option to seek dental care from a pediatric dentist through the age of 13, whether or not the child has an assigned general dentist. Referrals to visit a pediatric specialist are not required. If the pediatric dentist determines that additional specialty care is needed, they may refer pediatric patients directly to other specialists, such as an orthodontist. At age 14, covered dependent children must obtain care from their assigned DeltaCare USA general dentist.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2026 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	YOU PAY
D0100-D0999	I. DIAGNOSTIC - <i>When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees.</i> *	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	\$20.00
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$15.00
D0171	Re-evaluation - post-operative office visit	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	\$15.00
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months, Either one (1) D0210 or one (1) D0330 permitted. This limitation does not apply if medically necessary</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i> ¹	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted. This limitation does not apply if medically necessary</i>	\$5.00
D0396	3D printing of a 3D dental surface scan	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0461	Testing for cracked tooth	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost

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

D1000-D1999 II. PREVENTIVE - When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees.*

D1110	Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period ¹	No Cost
D1110	Additional prophylaxis cleaning - adult (within the 6 month period) ¹	\$25.00
D1120	Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period ¹	No Cost
D1120	Additional prophylaxis cleaning - child (within the 6 month period) ¹	\$25.00
D1208	Topical application of fluoride - excluding varnish - child to age 19; 1 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - through age 15	\$10.00
D1353	Sealant repair - per tooth - through age 15	\$10.00
D1510	Space maintainer - fixed - unilateral - per quadrant	\$135.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$135.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$135.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$160.00
D1526	Space maintainer - removable - bilateral, maxillary	\$180.00
D1527	Space maintainer - removable - bilateral, mandibular	\$180.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$15.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$15.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$15.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - child to age 9	\$135.00

D2000-D2999 III. RESTORATIVE - When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees.*

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
 - When there are more than six crowns in the same treatment plan, You may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of existing crowns, inlays and onlays requires the restoration to be 5+ years old. Replacement of a lost or stolen crown, inlay or onlay is not a covered Benefit. Please see Schedule B, Limitations and Exclusions of Benefits.

D2140	Amalgam - one surface, primary or permanent	\$10.00
D2150	Amalgam - two surfaces, primary or permanent	\$15.00
D2160	Amalgam - three surfaces, primary or permanent	\$25.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$35.00
D2330	Resin-based composite - one surface, anterior	\$30.00
D2331	Resin-based composite - two surfaces, anterior	\$40.00
D2332	Resin-based composite - three surfaces, anterior	\$50.00
D2335	Resin-based composite - four or more surfaces (anterior)	\$65.00
D2391	Resin-based composite - one surface, posterior	\$60.00
D2392	Resin-based composite - two surfaces, posterior	\$70.00
D2393	Resin-based composite - three surfaces, posterior	\$80.00
D2394	Resin-based composite - four or more surfaces, posterior	\$110.00
D2510	Inlay - metallic - one surface	\$287.00
D2520	Inlay - metallic - two surfaces	\$310.00
D2530	Inlay - metallic - three or more surfaces	\$335.00
D2542	Onlay - metallic - two surfaces	\$400.00
D2543	Onlay - metallic - three surfaces	\$405.00
D2544	Onlay - metallic - four or more surfaces	\$405.00
D2610	Inlay - porcelain/ceramic - one surface	\$385.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$395.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$405.00
D2740	Crown - porcelain/ceramic	\$575.00
D2750	Crown - porcelain fused to high noble metal	\$575.00
D2751	Crown - porcelain fused to predominantly base metal	\$525.00

D2752	Crown - porcelain fused to noble metal	\$550.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$575.00
D2790	Crown - full cast high noble metal	\$575.00
D2791	Crown - full cast predominantly base metal	\$525.00
D2792	Crown - full cast noble metal	\$550.00
D2794	Crown - titanium and titanium alloys	\$575.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$15.00
D2920	Re-cement or re-bond crown	\$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	\$65.00
D2930	Prefabricated stainless steel crown - primary tooth	\$80.00
D2940	Placement of interim direct restoration	\$15.00
D2949	Restorative foundation for an indirect restoration	\$75.00
D2950	Core buildup, including any pins when required	\$75.00
D2951	Pin retention - per tooth, in addition to restoration	\$15.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$150.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$80.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2962	Labial veneer (porcelain laminate) - indirect	\$575.00
D2976	Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i>	\$25.00
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
D2983	Veneer repair necessitated by restorative material failure	\$50.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>through age 15</i>	\$10.00

D3000-D3999

IV. ENDODONTICS - *When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees. **

D3110	Pulp cap - direct (excluding final restoration)	\$15.00
D3120	Pulp cap - indirect (excluding final restoration)	\$10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$40.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$150.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$225.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration)	\$260.00
D3331	Treatment of root canal obstruction; non-surgical access	\$150.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$150.00
D3346	Retreatment of previous root canal therapy - anterior	\$320.00
D3347	Retreatment of previous root canal therapy - premolar	\$380.00
D3348	Retreatment of previous root canal therapy - molar	\$460.00
D3410	Apicoectomy - anterior	\$125.00
D3421	Apicoectomy - premolar (first root)	\$170.00
D3425	Apicoectomy - molar (first root)	\$220.00
D3426	Apicoectomy (each additional root)	\$100.00
D3430	Retrograde filling - per root	\$40.00
D3450	Root amputation - per root	\$70.00
D3471	Surgical repair of root resorption - anterior	\$125.00
D3472	Surgical repair of root resorption - premolar	\$125.00
D3473	Surgical repair of root resorption - molar	\$125.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$125.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$125.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	\$125.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$80.00
D3921	Decoronation or submergence of an erupted tooth	\$15.00

D4000-D4999 V. PERIODONTICS - When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees. *

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$120.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$65.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$100.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$350.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$203.00
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	\$80.00
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	\$75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$45.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$27.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$50.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$45.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of an existing denture or partial denture requires the denture to be 5 or more years old. Replacement of a lost or stolen denture or partial denture is not a covered Benefit. Please see Exclusion #5 in Schedule B, Limitations and Exclusions of Benefits.

D5110	Complete denture - maxillary	\$620.00
D5120	Complete denture - mandibular	\$620.00
D5130	Immediate denture - maxillary	\$630.00
D5140	Immediate denture - mandibular	\$630.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$495.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$475.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$640.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$640.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$495.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$475.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$640.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$640.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery .	\$480.00

D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .	\$480.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$495.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$475.00
D5410	Adjust complete denture - maxillary	\$15.00
D5411	Adjust complete denture - mandibular	\$15.00
D5421	Adjust partial denture - maxillary	\$15.00
D5422	Adjust partial denture - mandibular	\$15.00
D5511	Repair broken complete denture base, mandibular	\$85.00
D5512	Repair broken complete denture base, maxillary	\$85.00
D5520	Replace missing or broken teeth - complete denture - per tooth	\$70.00
D5611	Repair resin partial denture base, mandibular	\$80.00
D5612	Repair resin partial denture base, maxillary	\$80.00
D5621	Repair cast partial framework, mandibular	\$80.00
D5622	Repair cast partial framework, maxillary	\$80.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$80.00
D5640	Replace missing or broken teeth - partial denture - per tooth	\$80.00
D5650	Add tooth to existing partial denture - per tooth	\$80.00
D5660	Add clasp to existing partial denture - per tooth	\$95.00
D5730	Reline complete maxillary denture (chairside)	\$60.00
D5731	Reline complete mandibular denture (chairside)	\$60.00
D5740	Reline maxillary partial denture (chairside)	\$60.00
D5741	Reline mandibular partial denture (chairside)	\$60.00
D5750	Reline complete maxillary denture (laboratory)	\$195.00
D5751	Reline complete mandibular denture (laboratory)	\$195.00
D5760	Reline maxillary partial denture (laboratory)	\$195.00
D5761	Reline mandibular partial denture (laboratory)	\$195.00
D5765	Soft liner for complete or partial removable denture - indirect	\$195.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	\$245.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i>	\$245.00
D5850	Tissue conditioning, maxillary	\$25.00
D5851	Tissue conditioning, mandibular	\$25.00
D5862	Precision attachment, by report	\$195.00

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])**

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per unit, beyond the 6th unit.

- Replacement of an existing crown, pontic or stress breaker requires the bridge to be 5 or more years old. Replacement of a lost or stolen crown, pontic or stress breaker is not a covered Benefit. Please see Exclusion #5 in Schedule B, Limitations and Exclusions of Benefits.

D6210	Pontic - cast high noble metal	\$575.00
D6211	Pontic - cast predominantly base metal	\$525.00
D6212	Pontic - cast noble metal	\$550.00
D6240	Pontic - porcelain fused to high noble metal	\$575.00
D6241	Pontic - porcelain fused to predominantly base metal	\$525.00
D6242	Pontic - porcelain fused to noble metal	\$550.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$550.00
D6245	Pontic - porcelain/ceramic	\$620.00
D6250	Pontic - resin with high noble metal	\$575.00
D6251	Pontic - resin with predominantly base metal	\$525.00
D6252	Pontic - resin with noble metal	\$550.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$190.00

D6549	Retainer - for resin bonded fixed prosthesis	\$190.00
D6720	Retainer crown - resin with high noble metal	\$575.00
D6721	Retainer crown - resin with predominantly base metal	\$525.00
D6722	Retainer crown - resin with noble metal	\$550.00
D6750	Retainer crown - porcelain fused to high noble metal	\$575.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$525.00
D6752	Retainer crown - porcelain fused to noble metal	\$550.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$575.00
D6780	Retainer crown - 3/4 cast high noble metal	\$575.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$525.00
D6782	Retainer crown - 3/4 cast noble metal	\$550.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$575.00
D6790	Retainer crown - full cast high noble metal	\$575.00
D6791	Retainer crown - full cast predominantly base metal	\$525.00
D6792	Retainer crown - full cast noble metal	\$550.00
D6930	Re-cement or re-bond fixed partial denture	\$55.00
D6940	Stress breaker	\$150.00
D6950	Precision attachment	\$195.00
D6980	Fixed partial denture repair necessitated by restorative material failure	\$195.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - When referable services are provided by a Contract Specialty Care Dentist, You pay 75 percent of that Dentist's submitted fees. *

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

D7111	Extraction, coronal remnants - primary tooth	\$15.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$15.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$50.00
D7220	Removal of impacted tooth - soft tissue	\$60.00
D7230	Removal of impacted tooth - partially bony	\$75.00
D7240	Removal of impacted tooth - completely bony	\$100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$135.00
D7250	Removal of residual tooth roots (cutting procedure)	\$40.00
D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i>	\$50.00
D7259	Nerve dissection - <i>available only when performed in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications</i>	No Cost
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$100.00
D7280	Exposure of an unerupted tooth	\$85.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	\$60.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$90.00
D7510	Incision and drainage of abscess - intraoral soft tissue	\$35.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost

D8000-D8999 XI. ORTHODONTICS

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

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

- Replacement of a lost, stolen or broken orthodontic appliance is not a covered Benefit. Please see Schedule B, Limitations and Exclusions of Benefits.

Pre and post orthodontic records include:

The Benefit for pre-treatment records and diagnostic services includes:

D0210	Intraoral - comprehensive series of radiographic images	\$200.00
D0322	Tomographic survey	

D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	<i>The Benefit for post-treatment records includes:</i>	\$70.00
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	**
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	**
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	**
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	**
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ..	**
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	**
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	**
D8091	Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i>	**
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8670	Periodic orthodontic treatment visit - <i>included in comprehensive orthodontic case fee</i>	No Cost
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery - <i>included in comprehensive orthodontic case fee</i>	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	**
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$100.00
D9000-D9999	XII. ADJUNCTIVE GENERAL SERVICES - <i>When referable services are provided by a Contract Specialist, You pay 75 percent of that Dentist's submitted fees.</i> *	
D9110	Palliative treatment of dental pain - per visit	\$25.00
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9230	Administration of nitrous oxide	\$15.00
D9239	Administration of moderate sedation intravenous - first 15 minute increment, or any portion thereof	\$35.00
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof	\$35.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$55.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$5.00
D9440	Office visit - after regularly scheduled hours	\$40.00
D9912	Pre-visit patient screening	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9936	Cleaning and inspection of occlusal guard - per appliance - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$10.00
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$210.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$210.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$210.00

D9951	Occlusal adjustment, limited	\$30.00
D9952	Occlusal adjustment, complete	\$145.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$155.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review .	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

* If services for a listed procedure are performed by the Contract Dentist, You pay 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% of the Contract Specialty Care Dentist's submitted fees. Specialized Services are only available upon referral by the Contract Dentist.

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.

Emergency Dental Services - The Contract Dentist will provide Emergency Dental Services for covered procedures whenever possible. If You require Emergency Dental Services and is unable to access care from the Contract Dentist, then We will reimburse You for the cost of such Emergency Dental Services which exceeds the Copayment. Emergency Dental Services is limited to listed procedures, and as described in code D9110 above: (Palliative (emergency) treatment of dental pain). Any further treatment of the cause of such Emergency Dental Services must be obtained from the Contract Dentist. All services are subject to the limitations and exclusions of the Plan.

FOOTNOTES

- ¹ *Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

SCHEDULE B

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. Placement of interim direct restoration is included in the fee for all covered Endodontic procedures (D3220-D3950) when done on the same date by the same Dentist/dental office.
4. The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure.
5. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
6. Benefits provided by a contract pediatric Dentist are available at 75 percent of the Contract Specialty Care Dentist's submitted fee. Referral by the Contract Dentist is required before services are rendered.
7. The cost to You receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.
8. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Your eligibility with this Plan are limited as follows:

Upon Your request, We will provide Benefits for the completion of covered services begun prior to the time Your coverage became effective. We will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. You may request completion of treatment in progress by calling the Customer Service department at 800 893-3582 during normal business hours, or by sending a written request to Us.

Whenever possible, You should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for Us to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by You and/or coverage provided by all plans is not more than 100 percent of total Allowable Expenses (as defined in the Coordination of Benefits section of the Evidence of Coverage).

Should You be unable to complete treatment with the Dentist who initiated the service, We will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.

9. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
10. Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.
11. Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.
12. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.

13. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).
14. X-ray Limitations (Does not apply if medically necessary):
 - When the frequencies for the comprehensive radiographic images (D0210) and panoramic radiographic images (D0330) differ, the least restrictive frequency will apply.
 - Panoramic images are not considered part of a comprehensive intraoral series.
 - Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
 - Bitewing x-rays are limited to two images for under age 10.
 - Image capture procedures are not separately billable services.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
 - * is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. 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.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered Benefits.
10. Dental services received from any dental facility other than the Contract Dentist including the services of an out-of-network Dentist who provides Specialized Services, unless expressly authorized by Us except for *Emergency Dental Services* as described in *Schedule A*.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Lost, stolen or broken orthodontic appliances.

14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, by report).
16. 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.
17. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed Dentist.
19. Services or supplies for sleep apnea.

As used in this Schedule submitted fees are the Contract Dentist's fees on file with Us and charged by the Contract Dentist for performing a specific dental service. Questions regarding these fees should be directed to the Customer Service department at 800-893-3582.

The following dental terms have the meanings indicated:

Abrasion - The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

Alveoloplasty - A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

Amalgam - A metal alloy used in filling teeth.

Apicoectomy - The surgical removal of the root tip.

Appliance - A device used to provide function or therapeutic effect.

Attrition - The normal loss of tooth substance resulting from friction during chewing.

Banding - Application of preformed stainless steel rings that are fitted around the teeth and cemented in place.

Banding dentition - Treatment of a tooth which involves banding (for orthodontic purposes).

Cephalometric x-rays - X-rays used in studying the measurements of the head in relation to specific soft tissue and bony reference points.

Cleft palate - A birth defect resulting in an incomplete closure or formation of the palate.

Debridement - The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

Equilibration - Changing the occlusal forms of the teeth by selective grinding, with the interest of balancing occlusal stresses more evenly on the teeth.

Erosion - Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

Exostosis - An excessive growth of bone.

Expansion appliance - An appliance used to widen a dental arch to increase the room available for permanent teeth and/or to correct the bite.

Frenum - The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

Frenectomy - Surgical removal or loosening of the frenum.

Functional appliance - An appliance used to achieve minor tooth movement, to strengthen the muscles of the oral cavity or to maintain space created by the loss or delayed eruption of the teeth.

Gingiva - The soft tissue which covers a tooth or the gum surrounding a tooth.

Gingivectomy - The surgical removal of the unsupported gingiva to the level where it is attached.

Gingivoplasty - Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

Headgear - An apparatus encircling the head or neck that provides attachment for an intraoral appliance in use of extraoral anchorage.

Implant - A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

Lingual - Pertaining to the tongue.

Macrogathia - A definite overgrowth of the mandible and maxilla.

Mandible - The lower jaw.

Mandibular - Pertaining to the lower jaw.

Maxilla - The upper jaw.

Maxillary - Pertaining to the upper jaw.

Micrognathia - An abnormal smallness of the jaws, especially the mandible.

Myofunctional therapy - Training to curb or eliminate abnormal muscle function of the oral cavity.

Occlusal - The chewing surfaces of the posterior teeth.

Occlusion - The contact between the upper and lower teeth when in a closed position.

Orthodontic appliance - Any appliance used to apply forces for tooth movement during orthodontic treatment.

Palate - The roof of the mouth.

Palatal - Pertaining to the roof of the mouth.

Palliative - Action that relieves pain but does not cure the cause of the pain.

Panoramic film - An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

Pediatric or **Pedodontic** - Pertaining to children.

Periapical - The area surrounding or enclosing the root tip of a tooth.

Periodontitis - Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

Periradicular - Around the root.

Pontic - The term used for the artificial tooth on a bridge.

Prophylaxis - The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

Pulp cap - The covering of an exposed dental nerve with material that protects it from foreign irritants.

Quadrant - One of the four equal sections into which the dental arches can be divided; begins at the middle of the arch and goes to the last tooth on either side.

Rebase - Process of refitting a denture by replacing the acrylic base material.

Resin - Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.

Retainer - An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

Retrograde filling - A method of sealing the root canal by preparing and filling it from the root tip.

Root planing - A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as “deep cleaning.”

Sealant - Application of a resin material to the biting surfaces of the permanent molars to seal the surface crevices to prevent the formation of decay.

Study model - A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

Supernumerary - Any tooth in excess of the 32 normal permanent teeth.

Temporomandibular joint - The joint formed by the connection of the lower jaw to the skull.

Tracing - As it relates to orthodontic treatment, a tracing is a line drawing of pertinent features of a cephalometric x-ray made on a piece of transparent paper placed over an x-ray. The tracing provides measurements of soft tissue and bony reference points that aid in predicting growth patterns and orthodontic diagnosis and treatment planning.

Trigeminal nerve - The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

Vertical dimension - The vertical height of the face with teeth in occlusion.

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1130 Sanctuary Parkway
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Customer Service agents are available Monday through Friday, 8 am to 9 pm ET. Or, use our automated phone system, available 24/7.

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Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009



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

This brochure is not intended to replace your legally required Evidence of Coverage. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the “Description of Benefits and Copayments” and “Limitations and Exclusions of Benefits” in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at **800-893-3582**.