Delta Dental Individual & Family™

DeltaCare® USA

Family Dental HMO

Plan Highlights

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

Sample of Covered Services[1]

Category	Procedure Code and Description[2]	Copayment Amount[3]	
		Pediatric Benefits	Adult Benefits
Diagnostic and Preventive Services	D0999 — Office visit	No charge	No charge
	D0120 — Periodic oral exam — established patient	No charge	No charge
	D0150 — Comprehensive oral evaluation — new or established patient	No charge	No charge
	D0210 — Complete series of x-rays	No charge	No charge
	D0220 — Periapical x-ray of tooth's root	No charge	No charge
	D0230 — Periapical x-ray of tooth's root, each additional image	No charge	No charge
	D0272 — Bitewing x-rays (2 images)	No charge	No charge
	D0274 — Bitewing x-rays (4 images)	No charge	No charge
	D0330 — Panoramic x-ray	No charge	No charge
	D1110 — Prophylaxis (cleaning) — adult	No charge	No charge
	D1120 — Prophylaxis (cleaning) — child	No charge	Not covered
	D1208 — Fluoride treatment	No charge	No charge
	D1351 — Sealant — per tooth	No charge	Not covered

[1] Featured benefits represent the most frequently used services covered under your plan; other services are also covered. After enrollment, DeltaCare USA will make available a complete list of covered services and copayments, along with any limitations and exclusions that apply. If applicable, service areas are detailed in the limitations and exclusions.

[2] Copayments and procedure descriptions referenced above are intended to clarify the delivery of benefits under the DeltaCare USA plan. They are not to be interpreted as CDT-2020 descriptors or nomenclature, which are under copyright by the American Dental Association.

[3] A copayment is the amount the enrollee pays for covered services at the time of treatment.

Category	Procedure Code and Description[2]	Copayment Amount[3]	
		Pediatric Benefits	Adult Benefits
Basic Services	D2140 — Amalgam (silver-colored) filling, 1 surface	$25	$25
	D2150 — Amalgam (silver-colored) filling, 2 surfaces	$30	$30
	D2160 — Amalgam (silver-colored) filling, 3 surfaces	$40	$40
	D2330 — Resin (tooth-colored) filling, front tooth, 1 surface	$30	$30
	D2331 — Resin (tooth-colored) filling, front tooth, 2 surfaces	$45	$45
	D2332 — Resin (tooth-colored) filling, front tooth, 3 surfaces	$55	$55
	D2391 — Resin (tooth-colored) filling, back tooth, 1 surface	$30	$30
	D2392 — Resin (tooth-colored) filling, back tooth, 2 surfaces	$40	$40
	D2393 — Resin (tooth-colored) filling, back tooth, 3 surfaces	$50	$50
Endodontics	D3310 — Root canal, front tooth	$195	$200
	D3320 — Root canal, premolar tooth	$235	$235
	D3330 — Root canal, molar tooth	$300	$300
Periodontics	D4260 — Periodontal surgery, per quadrant	$265	$265
	D4341 — Periodontal scaling and root planing — four or more teeth per quadrant	$55	$55
	D4910 — Periodontal maintenance	$30	$30
Oral Surgery	D7140 — Extraction (removal) of a fully exposed tooth	$65	$65
	D7210 — Extraction of erupted (exposed) tooth	$120	$115
	D7240 — Extraction of fully impacted tooth, completely bony	$160	$160
Major Services	D2750 — Crown, porcelain and precious metal	Not covered	$300
	D2790 — Crown, precious metal	Not covered	$300
	D5110 — Full upper denture	$300	$400
	D6240 — Bridge pontic, porcelain and precious metal	Not covered	$300
Orthodontics	D8080 — Pediatric services[4]	$350	Not covered

[4] Orthodontic Services for Pediatric Enrollees must meet medical necessity as determined by a dentist.