

Delta Dental Individual & Family™
DeltaCare® USA
Family Dental HMO



Dental benefits made easy.

What is DeltaCare USA?

DeltaCare USA is a copay plan that works similar to a dental HMO. With this type of plan, you must visit your selected DeltaCare USA dentist to receive benefits.¹ When you visit the dentist, simply pay your predefined copayment and you're all set! Since we provide a list of copayments for covered services up front, you can prepare for treatment costs ahead of time.

This plan has no waiting periods; you can use your benefits on the first day your coverage becomes effective.



Customer Service
888-857-0337
deltadentalins.com

Underwriter
Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Claims and Correspondence
P.O. Box 1803
Alpharetta, GA 30023

Is a DeltaCare USA plan right for me?

DeltaCare USA can be a great choice if you are budget conscious. Many enrollees appreciate the transparent pricing and affordable premiums the plans offer. Plus, with a large network of quality dentists, you can get great service close to home.

Need more reasons to love DeltaCare USA? Most diagnostic and preventive procedures, like routine cleanings, are offered at low or no copay. And if you need emergency dental care, even when you're away from home, we've got you covered with an emergency services provision.

Important tips

- This plan only covers you when you visit your selected DeltaCare USA dentist. We pick one for you when you enroll, but you can easily change your dentist online or on the phone.
- You can use our [Find a Dentist](#) tool to find a DeltaCare USA dentist near you. Too many choices? The included Yelp ratings may help you decide.
- Review the plan highlights on the next page to view copayments for the most common covered services. Want more? View the full copayment schedule, plus limitations and exclusions, [here](#).

Questions?



888-857-0337



deltadentalins.com

This benefit information is only a summary and is not intended to replace or serve as the plan Policy. Please consult the plan Policy for a description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the plan Policy, the terms of the Policy will prevail. For a complete copay schedule, limitations and exclusions, [click here](#) or call **888-857-0337**.

¹ Change your selected network dentist at any time online, by phone or in writing. Changes made by the 21st of the month are effective the first day of the following month.

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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 Services¹

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.

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이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 888-857-0337 (TTY: 711)번으로 연락하십시오. (Korean)

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צי קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט, עמעצער דא קען אייך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין אייער שפראך. פאר אומזיסטע הילף קענט איר אנקלינגען אט די דאזיקע נומער: 888-857-0337 ס'איז דא א נומער פאר מענטשען, וואס הערן ניט: 711 (Yiddish)

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