DELTA DENTAL

Delta Dental of Illinois
Dental Benefit Highlight Sheet

Lurie Children's Hospital **Group #10126**

Delta Dental of Illinois is pleased to be your dental benefits carrier. Your group plan offers you the dental benefit program: DeltaCare Illinois.

DeltaCare

- Your DeltaCare plan is designed to make dental care affordable and convenient for you and your covered dependents. Under this plan, you pay only the patient copayment for a covered procedure. There are no deductibles, no annual benefit maximums and no claim forms to complete. **Please see the enclosed DeltaCare Highlight, which provides examples of common procedures and the associated copayments. For orthodontia, additional records and retention copayments may apply.**
- In order to receive dental benefits, you must receive services from a dentist in the DeltaCare network and this dentist must be the primary dentist for you and your covered dependents. You and your covered dependents are then included on a monthly roster sent to DeltaCare primary network dentists. **Rosters are sent the 1st of each month. You should call the office first to ensure the office has received the roster and you can schedule an appointment. PLEASE NOTE: PEDIATRIC DENTISTS AND ORTHODONTISTS ARE SPECIALISTS.** Pediatric dentists are available to children 4 and younger.

How DeltaCare Works

- The DeltaCare general dentist you select when you enroll in this DeltaCare plan is your and your covered dependents primary dentist and will provide all routine dental care for you and your covered dependents.
- If specialty care is required, your primary dentist will refer you to a specialist who is also a member of the DeltaCare network. You will need a written referral in order to visit a specialist. PLEASE NOTE: PEDIATRIC DENTISTS AND ORTHODONTISTS ARE SPECIALISTS.
- When you visit your primary dentist, you pay the copayment for a given procedure according to your DeltaCare plan. Please note: some procedures are specialized and have a limited benefit, and you pay the listed copayment plus the difference between the dentist's usual fee for the applicable covered treatment and the dentist's usual fees for the specialized treatment. These procedures are noted on your DeltaCare Highlight. For orthodontia, additional records and retention copayments may apply.

Finding a Primary DeltaCare Dentist

Referrals to specialists, including pediatric dentists, are required.

Changing Your Primary Care Dentist

- You can change your primary dentist at any time by calling our customer service department at 800-942-3772. However, all changes must be received prior to the 20th of the month in order for your change to be effective for the upcoming month. If you make a change after the 20th of the month, your change will take effect the next month.
- If you need to see a specialist, your primary dentist must provide a written referral to a DeltaCare network specialist per program guidelines). There is an authorization process for both non-emergency and emergency referrals. Please contact our customer service department at 800-942-3772 to confirm the specialist's eligibility on any referrals provided. PLEASE NOTE: PEDIATRIC DENTISTS AND ORTHODONTISTS ARE SPECIALISTS.

DeltaCare Standards of Care

Non-Emergency

- The first available appointment, regardless of time or day, for a new patient examination is within four weeks.
- The first available appointment, regardless of time or day, for a routine follow-up appointment with a dentist is within four weeks.
- The first available hygiene appointment, regardless of time or day, is within six weeks.

Emergency

- Triage and/or palliative care, if needed, must be available 24/7 for– severe dental/oral pain, bleeding or swelling; or dental emergencies that risk life or disability without timely professional care.

If you are more than 35 miles from your primary dentist or are unable to see your primary dentist within 24 hours AND you require emergency treatment, you may go to any dentist and will be reimbursed for the treatment cost, less any applicable co-payment amount, up to a maximum of $50 once during any 12-month period. Please note that emergency treatment and reimbursement for that treatment is intended for the relief of severe dental/oral pain or to treat dental emergencies that risk life or disability without professional care. Follow-up care for treatment completion must be performed by your primary DeltaCare DHMO dentist.

If you are in this situation, you must contact customer service within 24 hours of treatment for authorization. You must also submit the dentist's statement and proof of payment for emergency services within 90 days after receiving treatment. If a DeltaCare dentist is not available in the timeframes designated, please contact Delta Dental of Illinois Customer Service at 800-942-3772 and we will immediately investigate the specific reason for the unavailability.

Customer Service

Call 800-942-3772 speak to a customer service representative from 7 a.m. to 7 p.m. Monday through Thursday and 7 a.m. to 6 p.m. Friday.

DELTA DENTAL

Ann & Robert H. Lurie Children's Hospital of Chicago™

HIGHLIGHTS OF DELTA DENTAL OF ILLINOIS DELTACARE PROGRAM PLAN 285

CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	$0
DIAGNOSTIC		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral radiographs - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
PREVENTIVE		
D1110	Prophylaxis (cleaning) - adult	$0
D1120	Prophylaxis (cleaning) - child	$0
D1201	Topical application of fluoride (including prophylaxis - child (to age 19)	$0
D1203	Topical application of fluoride (prophylaxis not included) - child (to age 19)	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant, per tooth (through age 15)	$10.00
D1510	Space maintainer - fixed - unilateral	$75.00
D1515	Space maintainer - fixed - bilateral	$75.00
D1520	Space maintainer - removable - unilateral	$75.00
D1525	Space maintainer - removable - bilateral	$75.00
D1550	Recementation of space maintainer	$10.00
	Diagnostic and Preventive services may be subject to frequency limitations. See your booklet for details.	
RESTORATIVE		
D2140	Amalgam - one surface, primary or permanent	$13.00
D2150	Amalgam - two surfaces, primary or permanent	$22.00
D2160	Amalgam - three surfaces, primary or permanent	$26.00
D2161	Amalgam - four or more surfaces, primary or perm.	$29.00
D2330	Resin-based composite - one surface, anterior	$30.00
D2331	Resin-based composite - two surfaces, anterior	$35.00

CODE	PROCEDURE	PATIENT PAYS
RESTORATIVE (cont.)		
D2332	Resin-based composite - three surfaces, anterior	$43.00
D2335	Resin-based composite, four or more surfaces or involving incisal angle (anterior)	$47.00
D2390	Resin-based composite crown, anterior	$135.00
D2391	Resin-based composite - one surface, posterior	$13.00†
D2392	Resin-based composite - two surfaces, posterior	$22.00†
D2393	Resin-based composite - three surfaces, posterior	$26.00†
D2394	Resin-based composite - four or more surfaces, post.	$29.00†
D2910	Recement inlay, only or partial coverage rest.	$25.00
D2920	Recement crown	$25.00
D2940	Sedative filling	$11.00
D2951	Pin retention - per tooth, in addition to rest.	$17.00
CROWNS/BRIDGES		
D2710	Crown - resin (indirect)	$135.00
D2720	Crown - resin with high noble metal*	$297.00
D2721	Crown - resin with predominantly base metal	$297.00
D2722	Crown - resin with noble metal	$297.00
D2740	Crown - porcelain/ceramic substrate	$297.00
D2750	Crown - porcelain fused to high noble*	$297.00
D2751	Crown - porcelain fused to predom. base metal	$297.00
D2752	Crown - porcelain fused to noble metal	$297.00
D2780	Crown - ¾ cast high noble metal*	$297.00
D2781	Crown - ¾ cast predom. base metal	$297.00
D2782	Crown - ¾ cast noble metal	$297.00
D2783	Crown - ¾ porcelain/ceramic	$297.00
D2790	Crown - full cast high noble metal*	$297.00
D2791	Crown - full cast predominantly base metal	$297.00
D2792	Crown - full cast noble metal	$297.00
D2794	Crown - titanium	$297.00
D2910	Recement inlay, onlay or partial coverage rest.	$25.00
D2915	Recement cast or prefab. post and core	$25.00
D2930	Prefab. stainless steel crown - prim. tooth	$125.00
D2931	Prefab. stainless steel crown - perm. tooth	$125.00
D2932	Prefab. resin crown [anterior teeth only]	$125.00
D2933	Prefab. stainless steel crown with resin window	$125.00†
D2950	Core buildup, including any pins	$82.00
D2951	Pin retention - per tooth, in addition to rest.	$17.00
D2952	Cast post and core in addition to crown*	$125.00
D2953	Each additional cast post - same tooth*	$125.00
D2954	Prefab. post and core in addition to crown	$93.00
D2957	Each additional prefab. post - same tooth	$93.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$87.00
D6210	Pontic - cast high noble metal*	$297.00
D6211	Pontic - cast predominantly base metal	$297.00
D6240	Pontic - porcelain fused to high noble metal*	$297.00
D6241	Pontic - porcelain fused to predom. base metal	$297.00
D6242	Pontic - porcelain fused to noble metal	$297.00
D6250	Pontic - resin with high noble metal*	$297.00

CODE	PROCEDURE	PATIENT PAYS
CROWNS/BRIDGES (cont.)		
D6251	Pontic - resin with predom. base metal	$297.00
D6252	Pontic - resin with noble metal	$297.00
D6750	Crown - porcelain fused to high noble metal*	$297.00
D6790	Crown - full cast high noble metal*	$297.00
D6930	Recement fixed partial denture	$40.00
D6971	Cast post as part of fixed partial denture retainer	$125.00
ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	$11.00
D3120	Pulp cap - indirect (excluding final restoration)	$8.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	$55.00
D3221	Pulpal debridement, primary and permanent teeth	$55.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$30.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$30.00
D3310	[Root canal] - anterior (excluding final restoration)	$97.00
D3320	[Root canal] - bicuspid (excluding final restoration)	$119.00
D3330	[Root canal] - molar (excluding final restoration)	$275.00
D3346	Retreatment of previous root canal therapy - anterior	$290.00
D3347	Retreatment of previous root canal therapy - bicuspid	$365.00
D3348	Retreatment of previous root canal therapy - molar	$465.00
D3410	Apicoectomy/periradicular surgery - anterior	$260.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$260.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$260.00
D3426	Apicoectomy/periradicular surgery (ea. add'l. root)	$88.00
D3430	Retrograde filling - per root	$65.00
PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quad.	$165.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth, per quadrant	$165.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$330.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth, per quadrant	$330.00
D4341	Periodontal scaling/root planing - 4 or more per quad.	$45.00
D4342	Periodontal scaling/root planing - one to three teeth, per quadrant	$45.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$45.00
PROSTHODONTICS-REMOVABLE*		
D5110	Complete denture - maxillary**	$380.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)**	$380.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	$420.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$420.00†
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$420.00†

CODE	PROCEDURE	PATIENT PAYS
PROSTHODONTICS-REMOVABLE* (cont.)		
D5410	Adjust complete denture - maxillary	$18.00
D5421	Adjust partial denture - maxillary	$18.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$50.00
D5630	Repair or replace broken clasp	$75.00
REPAIRS TO PROSTHETICS		
D5510	Repair broken complete denture base	$60.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$50.00
D5610	Repair resin denture base	$60.00
D5640	Replace broken teeth - per tooth	$53.00
D5650	Add tooth to existing partial denture	$85.00
D5660	Add clasp to existing partial denture	$99.00
D5710	Rebase complete maxillary denture	$160.00
D5720	Rebase maxillary partial denture	$160.00
D5730	Reline complete maxillary denture (chairside)	$80.00
D5740	Reline maxillary partial denture (chairside)	$80.00
D5750	Reline complete maxillary denture (laboratory)	$140.00
D5760	Reline maxillary partial denture (laboratory)	$140.00
ORAL SURGERY		
D7111	Extraction, coronal remnants - deciduous tooth	$18.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$18.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, minor smoothing of socket bone closure	$65.00
D7220	Removal of impacted tooth - soft tissue	$85.00
D7230	Removal of impacted tooth - partially bony	$120.00
D7240	Removal of impacted tooth - completely bony	$145.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$145.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$65.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$80.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$120.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$120.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$170.00
OTHER (ADJUNCTIVE) SERVICES		
D9110	Pallative (emergency) treatment of dental plan - minor procedure	$20.00
D9215	Local anesthesia	$0
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$20.00
D9450	Case presentation, detailed and extensive treatment	$0

CODE	PROCEDURE	PATIENT PAYS
ORTHODONTICS		
D8080	Comprehensive orthodontic treatment of the adolescent dentition***	$2,125.00
D8090	Comprehensive orthodontic treatment of the adult dentition***	$2,625.00
ORTHODONTICS (cont.)		
D8660	Pre-orthodontic treatment visit [applied to treatment fee if patient proceeds with treatment]	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)*	$250.00

"Patient Pays" applies to those procedures provided by the member's primary care dentist or approved specialty dentist.

*All charges for crown and bridge are per unit. There will be an additional patient charge for the actual cost for gold/high noble metal including any upgrade in materials such as porcelain.

**Includes any adjustments for 6 months.

***Plan benefits are for active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding, and the retention phase. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of two years. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to an office visit fee, not to exceed $75 per month.

†These procedures are specialized and considered a limited benefit. For these procedures, the patient pays the listed copayment plus the difference between the dentist's usual fees for the applicable covered benefit and the dentist's usual fees for the specialized treatment. For example, for a maxillary partial denture with a flexible base (D5225), the patient would pay the copay plus the difference between the dentist's usual fee for this procedure and the usual fee for the covered benefit, a maxillary partial denture resin base (D5213).

This is a brief description of your DeltaCare dental plan. Please consult your Certificate of Coverage for the complete Schedule of Dental Benefits, as well as the terms and conditions of coverage and any limitations and exclusions. Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment Delta Dental is required to make.

Your DeltaCare dental HMO plan is designed to make dental care affordable and convenient for you and your family. Under this plan, you pay only the patient copayment amount listed in the Schedule of Dental Benefits. There are no deductibles, no annual benefit maximums and no claim forms to complete.

How DeltaCare Works

The panel dentist you select when you enroll in this DeltaCare plan will provide all routine dental care for you and your family. If specialty care is required, your panel dentist will refer you to a specialist who is also a member of the DeltaCare network. You will need a written referral in order to visit a specialist.

You may select a new panel dentist at any time, however you must notify the DeltaCare administrator. Change requests received prior to the 20th of the month become effective on the first day of the following month.

Emergency Treatment

If you require emergency treatment and you are more than 35 miles from your panel dentist's office or you are unable to schedule an appointment with your panel dentist within 24 hours, you may go to any licensed dentist. Upon submission of the dentist's statement and your proof of payment, Delta Dental will reimburse you up to $50 (less any copayment amount) in any year for the cost of emergency treatment.

About the Procedures

The procedures listed below are performed as needed and deemed necessary by the DeltaCare network dentist and are subject to the limitations and exclusions of the program. Please refer to those sections for further clarification of benefits.

These procedures are specialized and considered a limited benefit. For these procedures, the patient pays the listed copayment plus the difference between the dentist's usual fees for the applicable covered benefit and the dentist's usual fees for the specialized treatment. For example, for a maxillary partial denture with a flexible base (D5225), the patient would pay the copay plus the difference between the dentist's usual fee for this procedure and the usual fee for the covered benefit, a maxillary partial denture resin base (D5213).

Missed appointments without 24 hr. notice are subject to a $10.00 charge per 15 minutes of appointment time.

Any procedure not listed is available on a fee-for-service basis.

If you have questions

Contact Delta Dental of Illinois at 800-942-3772.

EXCLUSIONS OF BENEFITS

1) General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.
2) Dental procedures performed for purely cosmetic purposes.
3) Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.
4) Treatment required by reason of war, declared or undeclared.
5) Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6) Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities.
7) Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
8) Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment.
9) Any service that is not specifically listed as a covered expense.
10) Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function. This exclusion does not apply to newly born children.
11) Cysts and malignancies.
12) Prescription drugs.
13) 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.
14) Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15) Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Treatment."
16) Prophylactic removal of impactions (asymptomatic, nonpathological).
17) "Consultations" for noncovered benefits.
18) Implant placement or removal, appliances placed on or services associated with implants including but not limited to prophylaxis and periodontal treatment.
19) Placement of a crown where there is sufficient tooth structure to retain a standard filling.
20) Porcelain crowns and porcelain fused to metal crowns on all molars.
21) Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
22) Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The patient must pay the difference in cost between the Dentist's usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit.
23) 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).
24) Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).
25) Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization.
26) Soft tissue management (irrigation, infusion, special toothbrush).
27) Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
28) Restorative work caused by orthodontic treatment.
29) Extractions solely for the purpose of orthodontics.

ORTHODONTIC EXCLUSIONS

1) Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers, and expansion appliances.
2) Retreatment of orthodontic cases.
3) Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
4) Surgical procedures incidental to orthodontic treatment.
5) Myofunctional therapy.
6) Surgical procedures related to cleft palate, micrognathia, or macrognathia.
7) Treatment related to temporomandibular joint disturbances.
8) Supplemental appliances not routinely utilized in typical Phase II orthodontics.
9) Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month.
10) Restorative work caused by orthodontic treatment.
11) Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion.
12) Extractions solely for the purpose of orthodontics.
13) Treatment in progress at inception of eligibility.
14) Transfer after banding has been initiated.
15) Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.