SCHEDULE A
Description of Benefits and Copayments
Alpha Dental Individual & Family
DeltaCare® USA
Basic Plan for Families

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). 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 this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 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.

Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Under Age 19)

Pediatric Enrollee	$375.00 each Calendar Year
Multiple Pediatric Enrollee	$750.00 each Calendar Year

OOPM applies only to Essential Health Benefits ("EHB") for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee(s) must pay for Benefits under this plan during a Calendar Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments or that are not covered under the Policy will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered under this Policy, the financial obligation for Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets their Pediatric Enrollee OOPM, they will have no further payment for the remainder of the Calendar Year for Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for Benefits.

Alpha recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If you have any questions regarding your OOPM, please contact the Customer Service Center at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	$15	$15	*For office visit, per visit (in addition to other services)*	*For office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	$5	$5	*1 per 11 months*	
D0140	Limited oral evaluation - problem focused	$5	$5	*3 per 6 months*	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$5	Not a benefit	*6 months up to age 3*	
D0150	Comprehensive oral evaluation - new or established patient	$5	$5	*1 per 12 months*	
D0160	Detailed and extensive oral evaluation - problem focused, by report	$5	$5		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$5	$5		
D0171	Re-evaluation - post-operative office visit	$10	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	Not a benefit	$5		
D0190	Screening of a patient	No cost	No cost	*1 (D0190, D0191) per 12 months*	*1 (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 (D0190, D0191) per 12 months*	*1 (D0190, D0191) per 12 months*
D0210	Intraoral - complete series of radiographic images	$25	$25	*1 per 11 months*	*1 series per 24 months*
D0220	Intraoral - periapical first radiographic image	$5	$5	*2 per 3 months*	
D0230	Intraoral - periapical each additional radiographic image	$5	$5	*Up to 17 images per 12 consecutive months*	
D0240	Intraoral - occlusal radiographic image	$5	$5	*2 per 12 months*	
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	Not a benefit	$5		
D0270	Bitewing - single radiographic image	$5	$5	*1 per 6 months*	
D0272	Bitewings - two radiographic images	$5	$5	*1 per 6 months*	
D0273	Bitewings - three radiographic images	$5	$5		
D0274	Bitewings - four radiographic images	$5	$5	*1 series per 6 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	$25	$25		
D0322	Tomographic survey	$25	Not a benefit		
D0330	Panoramic radiographic image	$25	$25	*1 per 36 months*	*1 series per 24 months*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$25	Not a benefit	*1 per 36 months*	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No cost	Not a benefit		
D0351	3D photographic image	No cost	Not a benefit		
D0415	Collection of microorganisms for culture and sensitivity	$25	$25		
D0416	Viral culture	$25	Not a benefit		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a benefit	$10		
D0460	Pulp vitality tests	$10	$10		
D0470	Diagnostic casts	$10	$10		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a benefit	$10		*Available only when performed in*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
					conjunction with a covered biopsy
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a benefit	$10		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a benefit	$10		*Available only when performed in conjunction with a covered biopsy*
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$25	Not a benefit		
D0502	Other oral pathology procedures, by report	$25	Not a benefit	*Performed by oral pathologists*	
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image - image capture only	No cost	No cost		
D0702	2D cephalometric radiographic image - image capture only	No cost	Not a benefit		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No cost	Not a benefit		
D0704	3D photographic image - image capture only	No cost	Not a benefit		
D0706	Intraoral - occlusal radiographic image - image capture only	No cost	No cost		
D0707	Intraoral - periapical radiographic image - image capture only	No cost	No cost		
D0708	Intraoral - bitewing radiographic image - image capture only	No cost	No cost		
D0709	Intraoral - complete series of radiographic images - image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D1110	Prophylaxis - adult	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a benefit	$45		*Up to 2 additional cleanings within the 12 month period*
D1120	Prophylaxis - child	$10	Not a benefit	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months*	
D1206	Topical application of fluoride varnish	No cost	No cost	*2 of (D1206, D1208) per 12 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride - excluding varnish	No cost	No cost	*2 of (D1206, D1208) per 12 months*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	Not a benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a benefit	No cost		
D1330	Oral hygiene instructions	Not a benefit	No cost		
D1351	Sealant - per tooth	$10	Not a benefit	*Permanent molars without restorations or decay; 1 per tooth per lifetime*	
D1353	Sealant repair - per tooth	$10	Not a benefit	*Permanent molars*	
D1354	Application of arresting medicament - per tooth	No cost	No cost	*2 per 12 months*	*2 per 12 months*
D1510	Space maintainer - fixed, unilateral - per quadrant	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1516	Space maintainer - fixed - bilateral, maxillary	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1517	Space maintainer - fixed - bilateral, mandibular	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1520	Space maintainer - removable, unilateral - per quadrant	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1526	Space maintainer - removable - bilateral, maxillary	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1527	Space maintainer - removable - bilateral, mandibular	$85	Not a benefit	*2 per 12 months; up to 4 per dentist*	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10	Not a benefit		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10	Not a benefit		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10	Not a benefit		
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10	Not a benefit	*Included in case by dentist/dental office who placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*	
D1557	Removal of fixed bilateral space maintainer - maxillary	$10	Not a benefit	*Included in case by dentist/dental office who*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
				placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office	
D1558	Removal of fixed bilateral space maintainer - mandibular	$10	Not a benefit	*Included in case by dentist/dental office who placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*	
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	$85	Not a benefit	*2 per 12 months; up to 4 per dentist; age 8 and under*	
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	$30	$30	*1 per 36 months per surface(s)*	
D2150	Amalgam - two surfaces, primary or permanent	$45	$45	*1 per 36 months per surface(s)*	
D2160	Amalgam - three surfaces, primary or permanent	$55	$55	*1 per 36 months per surface(s)*	
D2161	Amalgam - four or more surfaces, primary or permanent	$60	$60	*1 per 36 months per surface(s)*	
D2330	Resin-based composite - one surface, anterior	$70	$70	*1 per 36 months per surface(s)*	
D2331	Resin-based composite - two surfaces, anterior	$80	$80	*1 per 36 months per surface(s)*	
D2332	Resin-based composite - three surfaces, anterior	$90	$90	*1 per 36 months per surface(s)*	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$120	$120	*1 per 36 months per surface(s)*	
D2390	Resin-based composite crown, anterior	$120	$120	*1 per 36 months per surface(s)*	
D2391	Resin-based composite - one surface, posterior	$75	$75	*1 per 36 months per surface(s)*	
D2392	Resin-based composite - two surfaces, posterior	$85	$85	*1 per 36 months per surface(s)*	
D2393	Resin-based composite - three surfaces, posterior	$120	$120	*1 per 36 months per surface(s)*	
D2394	Resin-based composite - four or more surfaces, posterior	$125	$125	*1 per 36 months per surface(s)*	
D2510	Inlay - metallic - one surface	Not a benefit	$260		*Base metal is the benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	Not a benefit	$280		*Base metal is the benefit; 1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2542	Onlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	Not a benefit	$290		*Base metal is the benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not a benefit	$300		*Base metal is the benefit; 1 per 60 months*
D2610	Inlay - porcelain/ceramic - one surface	Not a benefit	$350		*1 per 60 months*
D2620	Inlay - porcelain/ceramic - two surfaces	Not a benefit	$385		*1 per 60 months*
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a benefit	$405		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not a benefit	$415		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not a benefit	$415		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a benefit	$425		*1 per 60 months*
D2650	Inlay - resin-based composite - one surface	Not a benefit	$250		*1 per 60 months*
D2651	Inlay - resin-based composite - two surfaces	Not a benefit	$275		*1 per 60 months*
D2652	Inlay - resin-based composite - three or more surfaces	Not a benefit	$310		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not a benefit	$305		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not a benefit	$330		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not a benefit	$375		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	Not a benefit	$125		*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	$320	$320	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a benefit	$485		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	$320	$320	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2722	Crown - resin with noble metal	Not a benefit	$465		*1 per 60 months*
D2740	Crown - porcelain/ceramic	$350	$350	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not a benefit	$485		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$320	$320	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not a benefit	$465		*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not a benefit	$485		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2781	Crown - 3/4 cast predominantly base metal	$350	$350	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not a benefit	$465		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	Not a benefit	$485		*1 per 60 months*
D2790	Crown - full cast high noble metal	Not a benefit	$485		*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$350	$350	*1 per tooth per lifetime, age 13 and up*	*1 per 60 months*
D2792	Crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D2794	Crown - titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15	$15	*1 per 12 months; included at no additional cost within 12 months of placement by the same Contract Dentist/office*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$15	$15	*1 per 12 months; included at no additional cost within 12 months of placement by the same Contract Dentist/office*	
D2920	Re-cement or re-bond crown	$15	$15	*1 per 12 months; included at no additional cost within 12 months of placement by the same Contract Dentist/office*	
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a benefit	$120		*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$170	$170	*1 per 36 months; through age 14*	
D2930	Prefabricated stainless steel crown - primary tooth	$110	Not a benefit	*1 per 36 months; through age 14*	
D2931	Prefabricated stainless steel crown - permanent tooth	$170	$170	*1 per 36 months; through age 14*	
D2932	Prefabricated resin crown	$170	Not a benefit	*Anterior primary tooth; 1 per 36 months*	
D2933	Prefabricated stainless steel crown with resin window	$140	Not a benefit	*Anterior primary tooth*	
D2940	Protective restoration	$10	$10	*2 per 6 months*	
D2949	Restorative foundation for an indirect restoration	Not a benefit	$90		
D2950	Core buildup, including any pins when required	$110	$110	*1 per 36 months*	
D2951	Pin retention - per tooth, in addition to restoration	$40	$40	*2 per 36 months*	
D2952	Post and core in addition to crown, indirectly fabricated	$140	$140	*Base metal post; includes canal preparation; 1 per lifetime*	*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	$40	$40	*Includes canal preparation*	*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	$130	$130	*Includes canal preparation*	*Includes canal preparation*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2955	Post removal	$110	$110		
D2957	Each additional prefabricated post - same tooth	$60	$60	*Includes canal preparation*	*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	$300	$300	*Limited to replacement of significant tooth structure loss due to caries or fracture*	*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	$340	$340	*Limited to replacement of significant tooth structure loss due to caries or fracture*	*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) - indirect	$350	$350	*Limited to replacement of significant tooth structure loss due to caries or fracture; 1 per lifetime per tooth*	*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a benefit	$100		
D2975	Coping	$70	Not a benefit		
D2980	Crown repair necessitated by restorative material failure	$50	$50		
D2981	Inlay repair necessitated by restorative material failure	Not a benefit	$50		
D2982	Onlay repair necessitated by restorative material failure	Not a benefit	$50		
D2983	Veneer repair necessitated by restorative material failure	Not a benefit	$50		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	$20	$20		
D3120	Pulp cap - indirect (excluding final restoration)	$20	$20		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$80	Not a benefit	*1 per 36 months*	
D3221	Pulpal debridement, primary and permanent teeth	Not a benefit	$45		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80	Not a benefit		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$80	Not a benefit		
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$80	Not a benefit		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$350	$350	*Root canal; 1 per lifetime per tooth*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$350	$350	*Root canal; 1 per lifetime per tooth*	*Root canal*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$350	$350	*Root canal; 1 per lifetime per tooth*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$350	$240		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$350	$240		
D3333	Internal root repair of perforation defects	Not a benefit	$200		
D3346	Retreatment of previous root canal therapy - anterior	Not a benefit	$500		
D3347	Retreatment of previous root canal therapy - premolar	Not a benefit	$600		
D3348	Retreatment of previous root canal therapy - molar	Not a benefit	$725		
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$120	Not a benefit		
D3352	Apexification/recalcification - interim medication replacement	$120	Not a benefit		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$240	Not a benefit	*1 per lifetime per tooth*	
D3410	Apicoectomy - anterior	$300	$300	*Per canal*	
D3421	Apicoectomy - premolar (first root)	$310	$310	*Per canal*	
D3425	Apicoectomy - molar (first root)	$330	$330	*Per canal*	
D3426	Apicoectomy (each additional root)	$130	$130	*Per canal*	
D3430	Retrograde filling - per root	$100	$100	*1 per lifetime per tooth*	
D3450	Root amputation - per root	$160	$160		
D3460	Endodontic endosseous implant	$350	Not a benefit		
D3471	Surgical repair of root resorption - anterior	$300	$300	*Per canal*	
D3472	Surgical repair of root resorption - premolar	$300	$300	*Per canal*	
D3473	Surgical repair of root resorption - molar	$300	$300	*Per canal*	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$300	$300	*Per canal*	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$300	$300	*Per canal*	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$300	$300	*Per canal*	
D3911	Intraorifice barrier	No cost	No cost		
D3920	Hemisection (including any root removal), not including root canal therapy	$80	$80		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D3950	Canal preparation and fitting of preformed dowel or post	$70	Not a benefit		
D3921	Decoronation or submergence of an erupted tooth	$70	$70		
D4000-D4999 V. PERIODONTICS					
- 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	$230	$230	*4 per 60 months*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$130	$130	*4 per 60 months*	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a benefit	$150		
D4230	Anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant	$90	Not a benefit		
D4231	Anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant	$50	Not a benefit		
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$240	$240		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$170	$170		
D4245	Apically positioned flap	Not a benefit	$135		
D4249	Clinical crown lengthening - hard tissue	$170	$170		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*4 per 60 months*	
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*4 per 60 months*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$140	$140		
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$50	$50		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$180	Not a benefit		
D4266	Guided tissue regeneration - resorbable barrier, per site	$150	$150		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$80	$80		
D4270	Pedicle soft tissue graft procedure	$140	$140		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$270	$270		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$120	$120		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a benefit	$350		
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$340	$340		
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$340	$340		
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$162	$270		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$350		
D4320	Provisional splinting - intracoronal	$50	Not a benefit		
D4321	Provisional splinting - extracoronal	$70	Not a benefit		
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	$50	Not a benefit		
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	$70	Not a benefit		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$110	$110	*4 per 12 months*	*1 per quadrant per 12 months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$70	$70	*4 per 12 months*	*1 per quadrant per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$60	$60		*1 treatment per 12 months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$20	$20	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*	*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	No cost	No cost	*For an additional tooth treated in the same quadrant following root planning or periodontal maintenance*	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	$60	$60	*1 treatment per 3 months*	*2 per 12 months*
D4910	Periodontal maintenance	Not a benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a benefit	$20		
D4921	Gingival irrigation - per quadrant	Not a benefit	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. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Denture or a partial denture is limited to 1 per 60 months. Replacement requires the existing denture to be 5+ years (60+ months) old.					
D5110	Complete denture - maxillary	$350	$350	*1 per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$350	$350	*1 per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$350	$350	*1 per 60 months*	*1 per 60 months*
D5140	Immediate denture - mandibular	$350	$350	*1 per 60 months*	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
	retentive/clasping materials, rests and teeth)				
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$350		*1 per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$350		*1 per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$350		*1 per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$350		*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$330	$330	*1 per 60 months; age 12 and up*	*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$330	$330	*1 per 60 months; age 12 and up*	*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$330	$330	*1 per 60 months; age 12 and up*	*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$330	$330	*1 per 60 months; age 12 and up*	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$50	$50	*Included in the fee for the original procedure,*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
				no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months	
D5411	Adjust complete denture - mandibular	$50	$50	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5421	Adjust partial denture - maxillary	$50	$50	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5422	Adjust partial denture - mandibular	$50	$50	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5511	Repair broken complete denture base, mandibular	$90	$90	*1 per 60 months*	
D5512	Repair broken complete denture base, maxillary	$90	$90	*1 per 60 months*	
D5520	Replace missing or broken teeth - complete denture (each tooth)	$70	$70	*1 per 60 months*	
D5611	Repair resin partial denture base, mandibular	$90	$90	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5612	Repair resin partial denture base, maxillary	$90	$90	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5621	Repair cast partial framework, mandibular	$120	$120	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5622	Repair cast partial framework, maxillary	$120	$120	*Included in the fee for the original procedure,*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
				no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months	
D5630	Repair or replace broken retentive clasping materials - per tooth	$100	$100	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5640	Replace broken teeth - per tooth	$80	$80	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5650	Add tooth to existing partial denture	$90	$90	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5660	Add clasp to existing partial denture - per tooth	$110	$110	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$290	$290	*Preauthorization is required for age 14 and up*	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$310	$310	*Preauthorization is required for age 14 and up*	
D5710	Rebase complete maxillary denture	Not a benefit	$180		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a benefit	$180		*1 per 12 months*
D5720	Rebase maxillary partial denture	Not a benefit	$180		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not a benefit	$180		*1 per 12 months*
D5725	Rebase hybrid prosthesis	Not a benefit	$180		*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$75	$75	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$75	$75	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D5740	Reline maxillary partial denture (direct)	$75	$75	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$75	$75	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$150	$150	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$150	$150	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$150	$150	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$150	$150	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	$150	$150	*1 per 6 months (6 months after initial placement)*	*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$230	$230	*1 per 60 months*	*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$230	$230	*1 per 60 months*	*1 per 12 months*
D5850	Tissue conditioning, maxillary	$40	$40	*1 per 12 months*	*1 per 12 months*
D5851	Tissue conditioning, mandibular	$40	$40	*1 per 12 months*	*1 per 12 months*
D5862	Precision attachment, by report	$170	Not a benefit		
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)					
D6205	Pontic - indirect resin based composite	Not a benefit	$410		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not a benefit	$485		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6212	Pontic - cast noble metal	Not a benefit	$465		*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	Not a benefit	$485		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not a benefit	$465		*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not a benefit	$465		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	Not a benefit	$460		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D6250	Pontic - resin with high noble metal	Not a benefit	$485		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a benefit	$465		*1 per 60 months*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a benefit	$335		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a benefit	$360		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a benefit	$270		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a benefit	$280		*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a benefit	$220		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a benefit	$230		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a benefit	$250		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a benefit	$260		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a benefit	$395		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a benefit	$425		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a benefit	$360		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a benefit	$380		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a benefit	$310		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a benefit	$330		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a benefit	$340		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a benefit	$360		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a benefit	$410		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a benefit	$485		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a benefit	$465		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	Not a benefit	$485		*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	Not a benefit	$485		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D6751	Retainer crown - porcelain fused to predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	Not a benefit	$465		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	Not a benefit	$485		*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not a benefit	$465		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	Not a benefit	$485		*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	Not a benefit	$485		*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	Not a benefit	$410		*1 per 60 months*
D6792	Retainer crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a benefit	$485		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$30	$30	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted within 6 months of placement; 1 per 6 months*	
D6940	Stress breaker	Not a benefit	$50		
D6980	Fixed partial denture repair necessitated by restorative material failure	Not a benefit	$75		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under local anesthetic. Post-operative services include exams, suture removal and treatment of complications.					
D7111	Extraction, coronal remnants - primary tooth	$50	$50		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$70	$70	*1 per lifetime per tooth*	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	$120	*1 per lifetime per tooth*	
D7220	Removal of impacted tooth - soft tissue	$140	$140	*1 per lifetime per tooth*	
D7230	Removal of impacted tooth - partially bony	$170	$170	*1 per lifetime per tooth*	
D7240	Removal of impacted tooth - completely bony	$220	$220	*1 per lifetime per tooth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$260	$260	*1 per lifetime per tooth*	
D7250	Removal of residual tooth roots (cutting procedure)	$130	$130	*1 per lifetime per tooth*	
D7251	Coronectomy - intentional partial tooth removal	$260	$230	*1 per lifetime per tooth*	
D7260	Oroantral fistula closure	$310	Not a benefit	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted by the original treating dentist within 91 days*	
D7261	Primary closure of a sinus perforation	$140	Not a benefit	*Included in the fee for the original procedure, no additional charge to the Enrollee is permitted by the original treating dentist within 91 days*	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$160	$160		
D7280	Exposure of an unerupted tooth	$130	$130	*1 per lifetime per tooth*	
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a benefit	$110		
D7283	Placement of device to facilitate eruption of impacted tooth	$140	$140		
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$100	Not a benefit		
D7286	Incisional biopsy of oral tissue-soft	$85	$85		
D7287	Exfoliative cytological sample collection	$80	Not a benefit		
D7288	Brush biopsy - transepithelial sample collection	$80	Not a benefit		
D7290	Surgical repositioning of teeth	$125	Not a benefit		
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$110	Not a benefit		
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap	$240	Not a benefit		
D7293	Placement of temporary anchorage device requiring flap	$350	Not a benefit		
D7294	Placement of temporary anchorage device without flap	$350	Not a benefit		
D7298	Removal of temporary anchorage device [screw retained plate], requiring flap	No cost	Not a benefit		
D7299	Removal of temporary anchorage device, requiring flap	No cost	Not a benefit		
D7300	Removal of temporary anchorage device without flap	No cost	Not a benefit		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$80	$80	*1 per quadrant per lifetime, up to 4 quadrants*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$90	$90	*1 per quadrant per lifetime, up to 4 quadrants*	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$90	$90	*1 per quadrant per lifetime, up to 4 quadrants*	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140	*1 per quadrant per lifetime, up to 4 quadrants*	
D7410	Excision of benign lesion up to 1.25 cm	$70	Not a benefit		
D7411	Excision of benign lesion greater than 1.25 cm	$90	Not a benefit		
D7412	Excision of benign lesion, complicated	$160	Not a benefit		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$30	Not a benefit		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$60	Not a benefit		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$150	$150		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$360	$360		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$90	Not a benefit		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$170	Not a benefit		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$50	Not a benefit		
D7471	Removal of lateral exostosis (maxilla or mandible)	Not a benefit	$150		
D7472	Removal of torus palatinus	$150	$150	*2 per lifetime*	
D7473	Removal of torus mandibularis	$150	$150	*2 per lifetime*	
D7490	Radical resection of maxilla or mandible	$350	Not a benefit		
D7510	Incision and drainage of abscess - intraoral soft tissue	$90	$90		
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$100	Not a benefit		
D7520	Incision and drainage of abscess - extraoral soft tissue	$90	Not a benefit		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated	$220	Not a benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
	(includes drainage of multiple fascial spaces)				
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$190	Not a benefit		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$90	Not a benefit		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$70	Not a benefit		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$70	Not a benefit		
D7610	Maxilla - open reduction (teeth immobilized, if present)	$350	Not a benefit		
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$350	Not a benefit		
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	Not a benefit		
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	Not a benefit		
D7650	Malar and/or zygomatic arch - open reduction	$350	Not a benefit	*1 per lifetime*	
D7660	Malar and/or zygomatic arch - closed reduction	$350	Not a benefit	*1 per lifetime*	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$140	Not a benefit		
D7671	Alveolus - open reduction, may include stabilization of teeth	$140	Not a benefit		
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	Not a benefit		
D7710	Maxilla - open reduction	$350	Not a benefit		
D7720	Maxilla - closed reduction	$350	Not a benefit		
D7730	Mandible - open reduction	$350	Not a benefit		
D7740	Mandible - closed reduction	$350	Not a benefit		
D7750	Malar and/or zygomatic arch - open reduction	$350	Not a benefit	*1 per lifetime*	
D7760	Malar and/or zygomatic arch - closed reduction	$350	Not a benefit		
D7770	Alveolus - open reduction stabilization of teeth	$350	Not a benefit		
D7771	Alveolus, closed reduction stabilization of teeth	$350	Not a benefit		
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	Not a benefit		
D7910	Suture of recent small wounds up to 5 cm	$50	Not a benefit		
D7911	Complicated suture - up to 5 cm	$30	Not a benefit		
D7912	Complicated suture - greater than 5 cm	$210	Not a benefit		
D7922	Placement of intra-socket biological dressing to aid in	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
	hemostasis or clot stabilization, per site				
D7940	Osteoplasty - for orthognathic deformities	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7941	Osteotomy - mandibular rami	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7944	Osteotomy - segmented or subapical	$350	Not a benefit	*Preauthorization is required*	
D7945	Osteotomy - body of mandible	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7946	LeFort I (maxilla - total)	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7947	LeFort I (maxilla - segmented)	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7949	LeFort II or LeFort III - with bone graft	$350	Not a benefit	*Preauthorization is required; 1 per lifetime*	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$350	Not a benefit		
D7953	Bone replacement graft for ridge preservation - per site	$225	Not a benefit		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$350	Not a benefit	*1 per 24 months*	
D7961	Buccal/labial frenectomy (frenulectomy)	$120	$120	*3 per lifetime*	
D7962	Lingual frenectomy (frenulectomy)	$120	$120	*3 per lifetime*	
D7963	Frenuloplasty	$160	Not a benefit		
D7970	Excision of hyperplastic tissue - per arch	$70	$70		
D7971	Excision of pericoronal gingiva	$50	$50		
D7979	Non-surgical sialolithotomy	$120	Not a benefit		
D7980	Surgical sialolithotomy	$120	Not a benefit		
D7981	Excision of salivary gland, by report	$350	Not a benefit		
D7982	Sialodochoplasty	$350	Not a benefit		
D7983	Closure of salivary fistula	$250	Not a benefit		
D7990	Emergency tracheotomy	$120	Not a benefit		
D7991	Coronoidectomy	$350	Not a benefit	*1 per lifetime*	
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report	$350	Not a benefit	*Preauthorization is required*	
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	$350	Not a benefit		
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY					

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
- Orthodontic Services must meet medical necessity as determined by a dentist. Orthodontic treatment is a benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.					
- Pediatric Enrollee must continue to be eligible, benefits for Medically Necessary Orthodontics will be provided in periodic payments to the Contract Dentist.					
- Comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted except for services provided by an orthodontist other than the original treating dentist or dental office.					
- Refer to Schedule B for Limitations and Exclusions for Medically Necessary Orthodontics for additional information.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	N/A		
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	N/A		
D8660	Pre-orthodontic treatment examination to monitor growth and development	$51	N/A	*1 per 6 month period when performed by the same Contract Dentist or dental office*	
D8670	Periodic orthodontic treatment visit	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No cost	N/A	*Placement of removable retainers; included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding*	
D8681	Removable orthodontic retainer adjustment	No cost	N/A		
D8698	Re-cement or re-bond fixed retainer - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8699	Re-cement or re-bond fixed retainer - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D8701	Repair of fixed retainer, includes reattachment - maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8702	Repair of fixed retainer, includes reattachment - mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8000-D8999 XI. ORTHODONTICS – for Adult Enrollees (age 19 and up)					
- Including covered dependent adult children. The Enrollee must continue to be eligible during active treatment.					
- The listed Copayment for each phase of orthodontic treatment (limited 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.					
Pre and post orthodontic records include:					
The benefit for pre-treatment records and diagnostic services includes:		N/A	$250		
D0210	Intraoral - complete series of radiographic images	N/A	Included		
D0322	Tomographic survey	N/A	Included		
D0330	Panoramic radiographic image	N/A	Included		
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	N/A	Included		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	N/A	Included		
D0351	3D photographic image	N/A	Included		
D0470	Diagnostic casts	N/A	Included		
D0701	Panoramic radiographic image - image capture only	N/A	Included		
D0702	2D cephalometric radiographic image - image capture only	N/A	Included		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	N/A	Included		
D0704	3D photographic image - image capture only	N/A	Included		
D0709	Intraoral - complete series of radiographic images - image capture only	N/A	Included		
The benefit for post-treatment records includes:		N/A	$70		
D0210	Intraoral - complete series of radiographic images	N/A	Included		
D0470	Diagnostic casts	N/A	Included		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0709	Intraoral - complete series of radiographic images - image capture only	N/A	Included		
D8040	Limited orthodontic treatment of the adult dentition	N/A	$1,950		
D8090	Comprehensive orthodontic treatment of the adult dentition	N/A	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	N/A	$25		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	N/A	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	N/A	$450		*Placement of removable retainers*
D8698	Re-cement or re-bond fixed retainer - maxillary	N/A	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	N/A	No cost		*2 per 6 months*
D8701	Repair of fixed retainer, includes reattachment - maxillary	N/A	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	N/A	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	N/A	$250		*Includes treatment planning session*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10	$10	*2 per 6 months*	
D9120	Fixed partial denture sectioning	$70	Not a benefit		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$30	Not a benefit		
D9211	Regional block anesthesia	Not a benefit	$25		
D9212	Trigeminal division block anesthesia	$25	$25		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$10	$10		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$5	$5		
D9222	Deep sedation/general anesthesia - first 15 minutes	$85	$85	*Covered only when given by a Contract Dentist for covered oral surgery; limited to 3 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$85	$85	*Covered only when given by a Contract Dentist for covered oral surgery; limited to 3 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$30	Not a benefit	*Per 30 minute increment (where available)*	
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$85	$85	*Covered only when given by a Contract Dentist for covered oral surgery; limited to 3 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$85	$85	*Covered only when given by a Contract Dentist for covered oral surgery; limited to 3 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery*
D9248	Non-intravenous conscious sedation	$110	Not a benefit	*(Where available)*	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$70	$70		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9410	House/extended care facility call	$70	Not a benefit		
D9420	Hospital or ambulatory surgical center call	$70	Not a benefit		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$10	$10		
D9440	Office visit - after regularly scheduled hours	$35	$35	*1 per 12 months*	
D9450	Case presentation, detailed and extensive treatment planning	Not a benefit	$25		
D9610	Therapeutic parenteral drug, single administration	$30	Not a benefit		
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$70	Not a benefit		
D9630	Drugs or medicaments dispensed in the office for home use	$10	Not a benefit		
D9912	Pre-visit patient screening	No cost	No cost		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$30	Not a benefit		
D9932	Cleaning and inspection of removable complete denture, maxillary	$5	$5		
D9933	Cleaning and inspection of removable complete denture, mandibular	$5	$5		
D9934	Cleaning and inspection of removable partial denture, maxillary	$5	$5		
D9935	Cleaning and inspection of removable partial denture, mandibular	$5	$5		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarifications/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D9942	Repair and/or reline of occlusal guard	$80	Not a benefit		
D9943	Occlusal guard adjustment	$10	$50	*1 per 12 months (6 months after initial placement)*	*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	$250	$250	*Preauthorization is required; 1 of (D9944, D9945, D9946) per 12 months*	*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard - soft appliance, full arch	$65	$65	*Preauthorization is required; 1 of (D9944, D9945, D9946) per 12 months*	*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard - hard appliance, partial arch	$125	$125	*Preauthorization is required; 1 of (D9944, D9945, D9946) per 12 months*	*1 of (D9944, D9945, D9946) per 36 months*
D9950	Occlusion analysis - mounted case	$175	Not a benefit		
D9951	Occlusal adjustment - limited	$40	$40		
D9952	Occlusal adjustment - complete	$230	$230		*1 per 36 months*
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a benefit	$125		*Limited to one bleaching tray and gel for two weeks of self treatment*
D9986	Missed appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9987	Cancelled appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	No cost	No cost		

Endnotes:

Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be preauthorized by the plan. The Enrollee pays the Copayment(s) specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable copayment for the covered procedure.

SCHEDULE B
Limitations and Exclusions of Benefits
Alpha Dental Individual & Family
DeltaCare® USA
Preferred Plan for Families / Basic Plan for Families

Limitations and Exclusions of Benefits for Adult Enrollees (Age 19 and Older)

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. 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).

4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service Center at 888-857-0337 if you have questions regarding the additional fee or name brand services;

5. Benefits for a soft tissue management program are limited to those parts, which are covered services listed on *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

6. The cost to an Enrollee receiving orthodontic treatment whose 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. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

   Exception to extend covered orthodontics Benefits to a cancelled or terminated Policy is as follows:
   a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or
   b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that 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.

4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ"), with the exception of procedures as shown on *Schedule A*.

6. 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.

7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

8. Consultations or other diagnostic services for non-covered Benefits.

9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Policy.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

11. Prescription and over-the-counter drugs.

12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

13. Changes in orthodontic treatment necessitated by accident of any kind.

14. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures as shown on *Schedule A*.

15. Composite or ceramic brackets, or lingual adaptation of orthodontic bands.

16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

17. Orthodontic, including oral evaluations and all treatment must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.

18. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under Age 19)

The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

Benefits and Limitations for Diagnostic Services for Pediatric Enrollees:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once every eleven (11) consecutive months.

3. Panoramic and cephalometric x-rays (D0330, D0340) are limited to once every thirty-six (36) consecutive months. Additional coverage is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

Benefits and Limitations for Preventive Services for Pediatric Enrollees:

1. Two routine prophylaxes (D1110, D1120) are covered in a 12 consecutive month period.

2. Two topical fluoride applications are covered in a 12 consecutive month period.

3. Sealants are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces. One sealant per tooth per lifetime.

4. Space maintainers are covered up to four appliances by a dentist and are limited to two in a 12 consecutive month period.

Benefits and Limitations for Restorative Services for Pediatric Enrollees:

1. Amalgam and resin-based composite restorations are limited to one (1) per 36 month period per tooth, per surface. Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 36 months of the original restoration are included, and a separate fee is not chargeable to the Enrollee by a Contract Dentist. However, coverage may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.

2. The covered restorations include all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.

3. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service Center at 888-857-0337 if you have questions regarding the additional fee or name brand services.

4. Permanent single crown restorations and posts and cores for Enrollees 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.) and is approved by the plan.

5. Core buildups (D2950) can be considered for Benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation. Limited to one (1) per thirty-sixty (36) consecutive months.

6. Crowns and posts and cores are covered only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, coverage is for that service. Crowns are limited to one (1) per tooth per lifetime. Crowns, inlays, onlays, buildups, or posts and cores, begun prior to the effective date of coverage or cemented after the cancellation date of coverage, are not eligible for coverage.

7. Recementation provided within 12 months of placement by the same dentist is included at no additional cost to the Enrollee.

8. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only covered when provided as part of a buildup for a crown.

9. Payment for a resin restoration will be made when a laboratory fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries

Benefits and Limitations for Endodontic Services for Pediatric Enrollees:

1. Pulpotomies are included when performed by the same dentist prior to the completion of root canal therapy.

2. A pulpotomy is covered when performed as a final endodontic procedure and is covered generally on primary teeth only. Pulpotomies performed on permanent teeth are included to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.

3. Pulpal therapy (resorbable filling) is limited to primary teeth only. It is a benefit for primary incisor teeth usually for Enrollees up to age six and for primary molars and cuspids usually to age 11.

4. Incomplete endodontic therapy is not a covered benefit when due to the patient discontinuing treatment.

5. For reporting and benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.

Benefits and Limitations for Periodontal Services for Pediatric Enrollees:

1. Gingivectomy or gingivoplasty and osseous surgery are limited to four (4) per 60 months.

2. Subepithelial connective tissue grafts and combined connective tissue and double pedicle grafts are covered at the level of free soft tissue grafts.

3. A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g., crater) or surfaces involved. Another site on the same tooth is included to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.

4. Guided tissue regeneration is covered only when provided to treat Class II furcation involvement or intrabony defects. It is not covered when provided to obtain root coverage, or when provided in conjunction with extractions, cyst removal or procedures involving the removal of a portion of a tooth, e.g., apicoectomy or hemisection.

5. Up to four periodontal maintenance procedures may be covered within a 12 consecutive month period.

6. Periodontal maintenance is only covered when performed following active periodontal treatment.

7. An oral evaluation reported in addition to periodontal maintenance will be covered as a separate procedure subject to the policy and limitations applicable to oral evaluations.

8. Coverage for multiple periodontal surgical procedures (except soft tissue grafts, osseous grafts, and guided tissue regeneration) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure.

Benefits and Limitations for Oral Surgery Services for Pediatric Enrollees:

1. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are included to the fee for reimplantation and/or stabilization.

2. Routine postoperative care such as suture removal is included to the fee for the surgery.

3. The removal of impacted teeth is covered based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, coverage will be based on the allowance for the lesser level.

4. Removal of impacted third molars in Enrollees under age 15 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the plan.

5. Alveoloplasty (D7310, D7311, D7320, D7321) is limited to one per quadrant per lifetime, up to four quadrants.

Benefits and Limitations for Prosthodontic Services for Pediatric Enrollees:

1. For reporting and benefit purposes, the completion date for crowns is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the dentist who fabricated the dentures may be reimbursed for the dentures after insertion if another dentist, typically an oral surgeon, inserted the dentures.

2. Removable cast base partial dentures for Enrollees under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the plan.

3. Re-cementation of bridges provided within 6 months of placement by the same dentist is included at no additional cost to the Enrollee.

4. A reline is covered once per denture during any 6 consecutive months.

5. Coverage for a denture made with precious metals is based on the allowance for a conventional denture.

6. A removable partial denture to replace all missing teeth in an arch is the benefit.

7. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered Benefits.

8. Replacement of removable prostheses is covered only if the existing removable prostheses was inserted at least five years (60+ months) prior to the replacement and satisfactory evidence is presented that the existing removable prostheses cannot be made serviceable. The five-year service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.

9. Replacement of appliances including, but not limited to, full or partial dentures, space maintainers, crowns and prostheses that have been lost, stolen, or misplaced is not a covered service.

10. Removable prostheses initiated prior to the effective date of coverage or inserted after the cancellation date of coverage are not eligible for coverage.

Policies, Limitations, and Exclusions for Orthodontic Services - Medically Necessary for Pediatric Enrollees:

1. Services are limited to medically necessary orthodontics when provided by a Contract Dentist. Orthodontic treatment is a benefit of this plan only when medically necessary as evidenced by a severe handicapping malocclusion for Pediatric Enrollees and shall be prior authorized by the plan.

2. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

3. The automatic qualifying conditions are:
   a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request.
   b. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate.
   c. A crossbite of individual anterior teeth causing destruction of soft tissue.
   d. Severe traumatic deviation.

4. The following documentation must be submitted to the plan with the request for prior Authorization of services by the Contract Dentist:
   - ADA 2006 or newer claim form with service code(s) requested;
   - Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   - Cephalometric radiographic image or panoramic radiographic image;
   - HLD score sheet completed and signed by the Orthodontist; and
   - Treatment plan.

5. The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.

6. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

7. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Pediatric Enrollees and shall be prior authorized.

8. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

9. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

10. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the plan will make an allowance for the cost of a standard orthodontic treatment.

11. Repair and replacement of an orthodontic appliance inserted under the plan that has been damaged, lost, stolen, or misplaced is not a covered service.

12. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

    If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, the plan will continue to provide orthodontic Benefits for:
    a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

13. Orthodontics, including oral evaluations and all treatment, must be provided by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.

14. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

Benefits and Limitations for General Services for Pediatric Enrollees:

1. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) and when rendered by a dentist or other professional licensed dentist and approved to provide anesthesia in the state where the service is rendered.

2. Deep sedation/general anesthesia and intravenous conscious sedation are covered only by report when determined to be medically or dentally necessary for documented handicapped or uncontrollable Enrollees or justifiable medical or dental conditions.

3. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted.

4. Deep sedation/general anesthesia and intravenous conscious sedation submitted without a report will be denied as a non-covered benefit.

5. For palliative (emergency) treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention.

6. In order for palliative (emergency) treatment to be covered, the dentist must provide treatment to alleviate the Enrollee's problem. If the only service provided is to evaluate the Enrollee and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.

7. Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.

8. Consultations for non-covered Benefits are not covered.

9. After hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the Enrollee in an emergency situation.

10. Therapeutic drug injections are only covered in unusual circumstances, which must be documented by report. They are not Benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

11. Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc., are not covered Benefits.

12. Occlusal guards are covered by report usually for Enrollees 13 years of age or older when the purpose of the occlusal guard is the treatment of bruxism and shall be prior authorized.

Exclusion of Benefits for Pediatric Enrollees:

Except as specifically provided, the following services, supplies, or charges are not covered:

1. Any dental service or treatment not specifically listed under *Schedule A, Description of Benefits and Copayments*, as a covered service.

2. Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of their license and applicable state law.

3. Services or treatment provided by a member of the Enrollee's immediate family.

4. Those services submitted by a dentist which are for the same services performed on the same date for the same Enrollee by another dentist.

5. Those which are experimental or investigative (deemed unproven).

6. Those which are for any illness or bodily injury which occurs in the course of employment if Benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the Enrollee claims the Benefits or compensation.

7. Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.

8. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.

9. Those for which the Enrollee would have no obligation to pay in the absence of this or any similar coverage.

10. Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

11. Those performed prior to the Enrollee's effective coverage date.

12. Those incurred after the termination date of the Enrollee's coverage unless otherwise indicated.

13. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the Enrollee by a Contract Dentist unless the dentist notifies the Enrollee of their liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records.)

14. Any procedure that has a 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 meeting accepted standards of dental practice.

15. Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.

16. Those performed by a dentist who is compensated by a facility for similar covered services performed for Enrollees.

17. Those resulting from the Enrollee's failure to comply with professionally prescribed treatment.

18. Any charges for failure to keep a scheduled appointment.

19. Duplicate and temporary devices, appliances, and services.

20. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction ("TMJD").

21. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

22. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

23. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.

24. Services or treatment provided as a result of intentionally self-inflicted injury or illness.

25. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.

26. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).

27. Adjunctive dental services as defined by applicable federal regulations.

28. Charges for copies of Enrollees' records, charts or x-rays, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or x-rays.

29. State or territorial taxes on dental services performed.

30. Adjunctive dental services as defined by applicable federal regulations. These are medical services that may be covered under a medical policy even when provided by a general dentist or oral surgeon

    1. Adjunctive dental care is dental care that is:
        a. Medically necessary in the treatment of an otherwise covered medical (not dental) condition.
        b. An integral part of the treatment of such medical condition.
        c. Essential to the control of the primary medical condition.
        d. Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

    2. The following diagnoses or conditions may fall under this category:
        a. Treatment for relief of Myofascial Pain Dysfunction Syndrome ("MFPS") or Temporomandibular Joint Dysfunction ("TMJD").
        b. Orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
        c. Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventive procedure under this plan.
        d. Treatment of total or complete ankyloglossia.
        e. Treatment of an extraoral abscess or intraoral abscess that extends beyond the dental alveolus.
        f. Treatment of cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.
        g. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

h. Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.)

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