SCHEDULE A
Description of Benefits and Copayments
Delta 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 which is 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 Enrollees	$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 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.

We recommend 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	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	$15	$15	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	No cost	No cost		
D0140	Limited oral evaluation - problem focused	No cost	No cost		
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No cost	Not a Benefit		
D0150	Comprehensive oral evaluation - new or established patient	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0160	Detailed and extensive oral evaluation - problem focused, by report	No cost	No cost		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	Not a Benefit	No cost		
D0171	Re-evaluation – post-operative office visit	Not a Benefit	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	No cost	No cost		
D0190	Screening of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral - complete series of radiographic images	$10	$10	*1 series per 36 months*	*1 series per 24 months*
D0220	Intraoral - periapical first radiographic image	No cost	No cost		
D0230	Intraoral - periapical each additional radiographic image	No cost	No cost		
D0240	Intraoral - occlusal radiographic image	No cost	No cost		
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	Not a Benefit	No cost		
D0270	Bitewing - single radiographic image	No cost	No cost		
D0272	Bitewings - two radiographic images	No cost	No cost		
D0273	Bitewings - three radiographic images	No cost	No cost		
D0274	Bitewings - four radiographic images	No cost	No cost	*1 series per 6 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No cost	$10		
D0330	Panoramic radiographic image	$10	$25	*1 per 36 months*	*1 series per 24 months*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$10	Not a Benefit		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$10	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No cost	Not a Benefit		
D0415	Collection of microorganisms for culture and sensitivity	Not a Benefit	No cost		
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	No cost		
D0460	Pulp vitality tests	Not a Benefit	No cost		
D0470	Diagnostic casts	$30	No cost		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a Benefit	No cost		*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	No cost		*Available only when performed in conjunction with a covered biopsy*
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		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
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		
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					
D1110	Prophylaxis - adult	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a Benefit	$45		*Up to 2 additional cleanings per 12 months*
D1120	Prophylaxis - child	$15	Not a Benefit	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	
D1206	Topical application of fluoride varnish	$10	$5	*1 of (D1206, D1208) per 6 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride – excluding varnish	$10	$5	*1 of (D1206, D1208) per 6 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	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 of (D1351, D1352) per tooth per 36 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1354	Application of caries arresting medicament – per tooth	$10	$5	*1 per 6 months*	*2 per 12 months*
D1510	Space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit		
D1516	Space maintainer – fixed – bilateral, maxillary	$195	Not a Benefit		
D1517	Space maintainer – fixed – bilateral, mandibular	$195	Not a Benefit		
D1520	Space maintainer – removable, unilateral – per quadrant	$140	Not a Benefit		
D1526	Space maintainer – removable – bilateral, maxillary	$195	Not a Benefit		
D1527	Space maintainer – removable – bilateral, mandibular	$195	Not a Benefit		
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$30	Not a Benefit		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$30	Not a Benefit		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$30	Not a Benefit		
D1556	Removal of fixed unilateral space maintainer - per quadrant	$15	Not a Benefit		
D1557	Removal of fixed bilateral space maintainer - maxillary	$15	Not a Benefit		
D1558	Removal of fixed bilateral space maintainer - mandibular	$15	Not a Benefit		
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	$150	Not a Benefit	*1 per quadrant per lifetime; Age 8 and under*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.					
D2140	Amalgam - one surface, primary or permanent	$45	$40		
D2150	Amalgam - two surfaces, primary or permanent	$60	$50		
D2160	Amalgam - three surfaces, primary or permanent	$70	$65		
D2161	Amalgam - four or more surfaces, primary or permanent	$85	$80		
D2330	Resin-based composite - one surface, anterior	$75	$70		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2331	Resin-based composite - two surfaces, anterior	$90	$85		
D2332	Resin-based composite - three surfaces, anterior	$100	$95		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$125	$120		
D2390	Resin-based composite crown, anterior	Not a Benefit	$190		
D2391	Resin-based composite - one surface, posterior	Not a Benefit	$75		
D2392	Resin-based composite - two surfaces, posterior	Not a Benefit	$90		
D2393	Resin-based composite - three surfaces, posterior	Not a Benefit	$105		
D2394	Resin-based composite - four or more surfaces, posterior	Not a Benefit	$125		
D2510	Inlay - metallic - one surface	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	$340	$340	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2542	Onlay - metallic - two surfaces	$335	$335	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*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*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
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)	Not a Benefit	$125		*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a Benefit	$425		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	Not a Benefit	$325		*1 per 60 months*
D2722	Crown - resin with noble metal	Not a Benefit	$425		*1 per 60 months*
D2740	Crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2790	Crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2792	Crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2794	Crown - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same dentist/office*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a Benefit	$45		
D2920	Re-cement or re-bond crown	$45	$45	*1 per 6 months; included at no additional cost within 12 months of placement by the same 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	$200	$200	*1 per 60 months; through age 14*	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$200	Not a Benefit	*1 per 60 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$130	Not a Benefit	*1 per 60 months; through age 14*	
D2931	Prefabricated stainless steel crown - permanent tooth	$200	$200	*1 per 60 months; through age 14*	
D2940	Protective restoration	$40	$25		
D2949	Restorative foundation for an indirect restoration	$125	$125		
D2950	Core buildup, including any pins when required	$125	$125	*1 per 60 months*	
D2951	Pin retention - per tooth, in addition to restoration	$30	$30		
D2952	Post and core in addition to crown, indirectly fabricated	Not a Benefit	$185		*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	Not a Benefit	$70		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	$120	$120	*1 per 60 months; includes canal preparation*	*Includes canal preparation*
D2955	Post removal	Not a Benefit	$40		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2957	Each additional prefabricated post - same tooth	Not a Benefit	$45		*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	Not a Benefit	$400		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	Not a Benefit	$440		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) - indirect	Not a Benefit	$500		*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		
D2980	Crown repair necessitated by restorative material failure	$110	$110		
D2981	Inlay repair necessitated by restorative material failure	$110	$110		
D2982	Onlay repair necessitated by restorative material failure	$110	$110		
D2983	Veneer repair necessitated by restorative material failure	$110	$110		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	Not a Benefit	$40		
D3120	Pulp cap - indirect (excluding final restoration)	Not a Benefit	$40		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$80	Not a Benefit		
D3221	Pulpal debridement, primary and permanent teeth	Not a Benefit	$70		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; through age 5*	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$80	Not a Benefit	*1 per tooth per lifetime; primary molars through age 11*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$270	$270	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$320	$320	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$390	$390	*Root canal; 1 per tooth per lifetime*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$270	$270		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$150	$150		
D3333	Internal root repair of perforation defects	Not a Benefit	$115		
D3346	Retreatment of previous root canal therapy - anterior	$350	$350		
D3347	Retreatment of previous root canal therapy - premolar	$350	$350		
D3348	Retreatment of previous root canal therapy - molar	$350	$350		
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$200	Not a Benefit		
D3352	Apexification/recalcification - interim medication replacement	$200	Not a Benefit		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$300	Not a Benefit		
D3355	Pulpal regeneration - initial visit	$175	Not a Benefit		
D3356	Pulpal regeneration - interim medication replacement	$88	Not a Benefit		
D3357	Pulpal regeneration - completion of treatment	$88	Not a Benefit		
D3410	Apicoectomy - anterior	$280	$280		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3421	Apicoectomy - premolar (first root)	$290	$290		
D3425	Apicoectomy - molar (first root)	$350	$350		
D3426	Apicoectomy (each additional root)	$150	$150		
D3430	Retrograde filling - per root	Not a Benefit	$120		
D3450	Root amputation - per root	$220	$220		
D3471	Surgical repair of root resorption - anterior	$280	$280		
D3472	Surgical repair of root resorption - premolar	$280	$280		
D3473	Surgical repair of root resorption - molar	$280	$280		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$280	$280		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$280	$280		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$280	$280		
D3911	Intraorifice barrier	No cost	No cost	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*	*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D3920	Hemisection (including any root removal), not including root canal therapy	$220	$220		
D3921	Decoronation or submergence of an erupted tooth	$85	$85		
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	$260	$260	*1 per 24 months per quadrant*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$150	$150	*1 per 24 months per quadrant*	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$150	$150	*1 per 24 months per quadrant*	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 24 months per quadrant*	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$200	$200	*1 per 24 months per quadrant*	
D4245	Apically positioned flap	Not a Benefit	$135		
D4249	Clinical crown lengthening - hard tissue	$280	$280	*1 per tooth per lifetime*	
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	*1 per 24 months per quadrant*	
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	*1 per 24 months per quadrant*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$255	$280	*1 per 24 months per quadrant*	
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not a Benefit	$150		
D4266	Guided tissue regeneration - resorbable barrier, per site	Not a Benefit	$210		
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not a Benefit	$240		
D4270	Pedicle soft tissue graft procedure	$350	$350		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350	$350		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a Benefit	$105		
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	$350	$350	*1 per 24 months per quadrant*	
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	$350	$350	*1 per 24 months per quadrant*	
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	$210	$210		
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	$210		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$110	$110	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$65	$65	*1 per quadrant per 24 months*	*1 per quadrant per 12 months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$15	$15	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$90	$90	*1 per lifetime*	*1 treatment per 12 months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$100	$100	*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 planing or periodontal maintenance*	*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	$60	$60	*4 treatments per 12 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	$25		
D4921	Gingival irrigation – per quadrant	No cost	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments, rebasing and relining, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments, rebasing and relining, 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.					
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.					
D5110	Complete denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5140	Immediate denture - mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) 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 of (D5211, D5213, D5221, D5223) per arch per 60 months*	*1 of (D5211, D5213, D5221, D5223, D5225, D5227) 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 of (D5212, D5214, D5222, D5224) per arch per 60 months*	*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5211, D5213, D5221, D5223, D5225, D5227) per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 of (D5212, D5214, D5222, D5224, D5226, D5228) per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$350	$350	*1 per arch per 60 months*	*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$315	$315	*1 per arch per 60 months*	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$40	$40		
D5411	Adjust complete denture - mandibular	$40	$40		
D5421	Adjust partial denture - maxillary	$40	$40		
D5422	Adjust partial denture - mandibular	$40	$40		
D5511	Repair broken complete denture base, mandibular	$90	$90		
D5512	Repair broken complete denture base, maxillary	$90	$90		
D5520	Replace missing or broken teeth - complete denture (each tooth)	$90	$90		
D5611	Repair resin partial denture base, mandibular	$90	$90		
D5612	Repair resin partial denture base, maxillary	$90	$90		
D5621	Repair cast partial framework, mandibular	$90	$90		
D5622	Repair cast partial framework, maxillary	$90	$90		
D5630	Repair or replace broken retentive clasping materials - per tooth	$120	$120		
D5640	Replace broken teeth - per tooth	$90	$90		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5650	Add tooth to existing partial denture	$90	$90		
D5660	Add clasp to existing partial denture - per tooth	$120	$120		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit	$290		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit	$290		
D5710	Rebase complete maxillary denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a Benefit	$260		*1 per 12 months*
D5720	Rebase maxillary partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5721	Rebase mandibular partial denture	$260	$260	*1 per 36 months*	*1 per 12 months*
D5725	Rebase hybrid prosthesis	$260	$260	*1 per 36 months*	*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$160	$160	*1 per 36 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$155	$155	*1 per 36 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$225	$225	*1 per 36 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$224	$224	*1 per 36 months*	*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	$224	$224	*1 per 36 months*	*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit	$300		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit	$300		*1 per 12 months*
D5850	Tissue conditioning, maxillary	$80	$80		*1 per 12 months*
D5851	Tissue conditioning, mandibular	$80	$80		*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES					
- Includes adjustments, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the implant was originally delivered.					
- Replacement of a retainer, pontic, or stress breaker requires the existing bridge to be 60+ months old.					
- FPD, as referenced below, stands for fixed partial denture.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6040	Surgical placement: eposteal implant	$350	Not a Benefit	*1 per 60 months*	
D6050	Surgical placement: transosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6055	Connecting bar – implant supported or abutment supported	$350	Not a Benefit	*1 per 60 months*	
D6056	Prefabricated abutment – includes modification and placement	$350	Not a Benefit	*1 per 60 months*	
D6058	Abutment supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6062	Abutment supported cast metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6064	Abutment supported cast metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6065	Implant supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6067	Implant supported crown - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6075	Implant supported retainer for ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$80	Not a Benefit		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$270	Not a Benefit		
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6083	Implant supported crown - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6085	Interim implant crown	No cost	Not a Benefit	*1 per 60 months*	
D6086	Implant supported crown - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6087	Implant supported crown - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6088	Implant supported crown - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6090	Repair implant supported prosthesis, by report	$350	Not a Benefit	*1 per 60 months*	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$270	Not a Benefit		
D6095	Repair implant abutment, by report	$350	Not a Benefit		
D6096	Remove broken implant retaining screw	$170	Not a Benefit	*1 per tooth per 60 months*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6100	Surgical removal of implant body	$250	Not a Benefit		
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$270	Not a Benefit		
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$350	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$255	Not a Benefit		
D6104	Bone graft at time of implant placement	$255	Not a Benefit		
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not a Benefit	*1 per 60 months*	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not a Benefit	*1 per 60 months*	
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6190	Radiographic/surgical implant index, by report	$200	Not a Benefit		
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.					
D6205	Pontic - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6210	Pontic - cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6212	Pontic - cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6241	Pontic - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250	Not a Benefit	*1 per 60 months*	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6549	Retainer – for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a Benefit	$385		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a Benefit	$380		*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a Benefit	$380		*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	$415		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a Benefit	$370		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a Benefit	$390		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a Benefit	$350		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a Benefit	$350		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a Benefit	$370		*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	$245		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6791	Retainer crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6792	Retainer crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a Benefit	$350		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$80	$80		
D6940	Stress breaker	Not a Benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	$170	$170		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D7111	Extraction, coronal remnants - primary tooth	Not a Benefit	$60		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$85	$85		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$140	$140		
D7220	Removal of impacted tooth - soft tissue	$150	$150		
D7230	Removal of impacted tooth - partially bony	$225	$225		
D7240	Removal of impacted tooth - completely bony	$245	$245		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220	$220		
D7250	Removal of residual tooth roots (cutting procedure)	$140	$140		
D7251	Coronectomy – intentional partial tooth removal	$245	$140		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$140	$140		
D7280	Exposure of an unerupted tooth	$155	$155		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a Benefit	$110		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7283	Placement of device to facilitate eruption of impacted tooth	Not a Benefit	$110		
D7286	Incisional biopsy of oral tissue - soft	Not a Benefit	$100		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$140	$140		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$140	$140		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a Benefit	$140		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a Benefit	$160		
D7471	Removal of lateral exostosis (maxilla or mandible)	$250	$250		
D7472	Removal of torus palatinus	Not a Benefit	$250		
D7473	Removal of torus mandibularis	Not a Benefit	$250		
D7510	Incision and drainage of abscess - intraoral soft tissue	$100	$100		
D7910	Suture of recent small wounds up to 5 cm	$80	Not a Benefit		
D7921	Collection and application of autologous blood concentrate product	$300	Not a Benefit		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No cost	No cost		
D7961	Buccal/labial frenectomy (frenulectomy)	Not a Benefit	$260		
D7962	Lingual frenectomy (frenulectomy)	Not a Benefit	$260		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7970	Excision of hyperplastic tissue - per arch	Not a Benefit	$115		
D7971	Excision of pericoronal gingiva	$130	$130		
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees (under age 19) ONLY					
- Orthodontic Services must meet medical necessity as determined by a Contract 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 (D8070, 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 Contract Dentist or dental office.					
- Refer to Schedule B for Limitations and Exclusions for medically necessary orthodontics for additional information.					
D8010	Limited orthodontic treatment of the primary dentition	$350	N/A		
D8020	Limited orthodontic treatment of the transitional dentition	$350	N/A		
D8030	Limited orthodontic treatment of the adolescent dentition	$350	N/A		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	N/A		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	N/A		
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	N/A		
D8210	Removable appliance therapy	$350	N/A		
D8220	Fixed appliance therapy	$350	N/A		
D8660	Pre-orthodontic treatment examination to monitor growth and development	$51	N/A	*1 per 6 months 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*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	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 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*	
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*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
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		
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		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8080	Comprehensive orthodontic treatment of the adolescent dentition	N/A	$3,250		
D8090	Comprehensive orthodontic treatment of the adult dentition	N/A	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	N/A	$51		*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*
D8681	Removable orthodontic retainer adjustment	N/A	No cost		
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	$45	$45		
D9211	Regional block anesthesia	Not a Benefit	No cost		
D9212	Trigeminal division block anesthesia	Not a Benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a Benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a Benefit	No cost		
D9222	Deep sedation/general anesthesia - first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
				(D9222, D9223) per date of service	*(D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$45	$45		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Not a Benefit	$10		
D9440	Office visit - after regularly scheduled hours	Not a Benefit	$45		
D9450	Case presentation, detailed and extensive treatment planning	Not a Benefit	$10		
D9610	Therapeutic parenteral drug, single administration	$40	Not a Benefit		
D9912	Pre-visit patient screening	No cost	No cost		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$45	Not a Benefit		
D9932	Cleaning and inspection of removable complete denture, maxillary	No cost	No cost		
D9933	Cleaning and inspection of removable complete denture, mandibular	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9934	Cleaning and inspection of removable partial denture, maxillary	No cost	No cost		
D9935	Cleaning and inspection of removable partial denture, mandibular	No cost	No cost		
D9943	Occlusal guard adjustment	$40	$40	*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	$295	$295	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard – soft appliance, full arch	$75	$75	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard – hard appliance, partial arch	$150	$150	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a Benefit	$65		
D9952	Occlusal adjustment - complete	Not a Benefit	$265		*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 1 bleaching tray and gel for 2 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*
D9990	Certified translation or sign language services - per visit	No cost	No cost		
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 an implant/abutment supported crown or fixed bridge retainer, indirectly fabricated post and core, inlay or onlay, the Enrollee will

be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

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 Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized in writing by Us. 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
Delta 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 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 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 listed 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 Contract 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 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 procedures started after termination of eligibility for coverage

13. 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.

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

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

16. Composite or ceramic brackets or lingual adaptation of orthodontic bands.

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

18. 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.

19. 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)

Limitations of Benefits for Pediatric Enrollees

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

1. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Additional coverage of Panoramic and cephalometric x-rays (D0330, D0340, D0701, D0702) is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

3. Sealants (D1351, D1352) are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

4. Space maintainers are a Benefit when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

5. Restorations, crowns, inlays and onlays are Benefits only if necessary to treat diseased or fractured teeth.

6. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm, frenectomy and crown lengthening.

7. Wisdom teeth (third molars) extracted for Enrollees under age 15 are not eligible for payment in the absence of specific pathology.

8. In the case of an Emergency Service involving pain or a condition requiring immediate treatment, the plan covers necessary diagnostic and therapeutic dental procedures administered by and Out-of-Network Dentist up to the difference between the Out-of- Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

9. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and

    b. Either of the following:
        i. The existing non-functional restoration/bridge/denture was placed 60 or more months prior to its replacement, or
        ii. If an existing partial denture is less than 60 months old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

10. Deep sedation/general anesthesia and/or intravenous moderate 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 soft tissue, partial or full bony impactions (Procedures D7220, D7230, D7240, and D7241).

11. Deep sedation/general anesthesia or intravenous moderate sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

12. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the Contract Dentist to treat the child and upon prior Authorization by Us, less applicable Copayments. The Plan will

consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.

Exclusions of Benefits for Pediatric Enrollees (Under age 19)

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. Dental services received from any dental facility other than the 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.

3. 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 his/her liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records.)

4. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

    a. 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

    b. is inconsistent with meeting accepted standards of dental practice.

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

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

7. Those resulting from the Enrollee's failure to comply with professionally prescribed treatment or due to lack of cooperation with the Contract Dentist or dental office.

8. Those started or performed prior to the Enrollee's effective coverage date.

9. Those incurred after the termination date of the Enrollee's eligibility for coverage unless otherwise indicated.

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

11. Services and/or appliances 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.

12. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

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

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

15. For implants, surgical insertion; and/or removal of, and any appliances and/or crowns attached to implants.

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

17. Deep sedation/general anesthesia for covered procedures on the same date of service as intravenous conscious sedation/analgesia.

18. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided prior Authorization is obtained.

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

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

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

22. 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.

23. 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 member claims the Benefits or compensation.

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

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

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

27. 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.

28. 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.

29. 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.

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

31. 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.

32. For assistant at surgery.

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

34. Any services that are considered strictly cosmetic in nature including, but not limited to, bleaching, veneer facing, bridges and/or denture, and charges for personalization or characterization of prosthetic appliances.

35. Services related to the diagnosis and treatment of jaw joint problems, including, but not limited, to Temporomandibular Joint Dysfunction (TMJD), craniomandibular disorders, or other conditions of the joint linking the jaw bone or the complex of muscles, nerves and other tissues related to that joint.

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

37. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

38. Prescription and over-the-counter drugs, home care items, vitamins or dietary supplements.

39. 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.

40. 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.

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

42. State or territorial taxes on dental services performed.

Policies, Limitations, and Exclusions for Medically Necessary Orthodontic Services 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 (D8070, 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. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the Contract Dentist's charge for the specialized orthodontic appliance or procedure.

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.

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