SCHEDULE A

Description of Benefits and Copayments *

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 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.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	$40.00
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$11.00

D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning*- adult - *limited to 2 D1110, D1120 or D4346 per calendar year*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 12 month period)*	$45.00
D1120	Prophylaxis cleaning - child - *limited to 2 D1110, D1120 or D4346 per calendar year*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 12 month period)*	$30.00
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$15.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$15.00
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 2 per calendar year*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$95.00
D1516	Space maintainer - fixed - bilateral, maxillary	$155.00
D1517	Space maintainer - fixed - bilateral, mandibular	$155.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$95.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $130.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	$16.00
D2150	Amalgam - two surfaces, primary or permanent	$21.00
D2160	Amalgam - three surfaces, primary or permanent	$26.00
D2161	Amalgam - four or more surfaces, primary or permanent	$32.00
D2330	Resin-based composite - one surface, anterior	$21.00
D2331	Resin-based composite - two surfaces, anterior	$26.00
D2332	Resin-based composite - three surfaces, anterior	$32.00
D2335	Resin-based composite - four or more surfaces (anterior)	$80.00
D2390	Resin-based composite crown, anterior	$105.00
D2391	Resin-based composite - one surface, posterior	$42.00
D2392	Resin-based composite - two surfaces, posterior	$53.00
D2393	Resin-based composite - three surfaces, posterior	$74.00
D2394	Resin-based composite - four or more surfaces, posterior	$100.00
D2510	Inlay - metallic - one surface	$410.00
D2520	Inlay - metallic - two surfaces	$410.00
D2530	Inlay - metallic - three or more surfaces	$410.00
D2542	Onlay - metallic - two surfaces	$470.00
D2543	Onlay - metallic - three surfaces	$470.00
D2544	Onlay - metallic - four or more surfaces	$470.00
D2740	Crown - porcelain/ceramic	$505.00
D2750	Crown - porcelain fused to high noble metal	$460.00
D2751	Crown - porcelain fused to predominantly base metal	$405.00
D2752	Crown - porcelain fused to noble metal	$430.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$460.00
D2780	Crown - 3/4 cast high noble metal	$460.00
D2781	Crown - 3/4 cast predominantly base metal	$405.00
D2782	Crown - 3/4 cast noble metal	$430.00
D2790	Crown - full cast high noble metal	$460.00
D2791	Crown - full cast predominantly base metal	$405.00
D2792	Crown - full cast noble metal	$430.00
D2794	Crown - titanium and titanium alloys	$460.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$41.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$41.00
D2920	Re-cement or re-bond crown	$41.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$80.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$98.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$98.00
D2930	Prefabricated stainless steel crown - primary tooth	$98.00
D2931	Prefabricated stainless steel crown - permanent tooth	$98.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$120.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$145.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$145.00

D2940	Placement of interim direct restoration	$13.00
D2949	Restorative foundation for an indirect restoration	$98.00
D2950	Core buildup, including any pins when required	$98.00
D2951	Pin retention - per tooth, in addition to restoration	$21.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$155.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$130.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2960	Labial veneer (resin laminate) - direct	$95.00
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	$26.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to 1 per 24 months*	$15.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$33.00
D3120	Pulp cap - indirect (excluding final restoration)	$33.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$78.00
D3221	Pulpal debridement, primary and permanent teeth	$78.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$78.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$315.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$370.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$505.00
D3331	Treatment of root canal obstruction; non-surgical access	$135.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$135.00
D3333	Internal root repair of perforation defects	$135.00
D3346	Retreatment of previous root canal therapy - anterior	$420.00
D3347	Retreatment of previous root canal therapy - premolar	$475.00
D3348	Retreatment of previous root canal therapy - molar	$605.00
D3410	Apicoectomy - anterior	$375.00
D3421	Apicoectomy - premolar (first root)	$405.00
D3425	Apicoectomy - molar (first root)	$430.00
D3426	Apicoectomy (each additional root)	$145.00
D3430	Retrograde filling - per root	$100.00
D3471	Surgical repair of root resorption - anterior	$375.00
D3472	Surgical repair of root resorption - premolar	$375.00
D3473	Surgical repair of root resorption - molar	$375.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$375.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$375.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$375.00

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	$240.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$120.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$295.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$155.00
D4245	Apically positioned flap	$295.00
D4249	Clinical crown lengthening - hard tissue	$325.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$595.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$310.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$290.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$225.00
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	$380.00
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	$430.00
D4270	Pedicle soft tissue graft procedure	$395.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$395.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$395.00
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	$198.00
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	$237.00
D4286	Removal of non-resorbable barrier	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$110.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$61.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *limited to 2 D1110, D1120 or D4346 per calendar year*	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$83.00

D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$45.00
D4910	Periodontal maintenance - *limited to 2 per calendar year*	$78.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	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. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$550.00
D5120	Complete denture - mandibular	$550.00
D5130	Immediate denture - maxillary	$550.00
D5140	Immediate denture - mandibular	$550.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$410.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$640.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$640.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$410.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$410.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$640.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$640.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery	$410.00
D5226	Mandibular partial denture - flexible base (including retentive/ clasping materials, rests, and teeth)	$410.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$410.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$410.00
D5410	Adjust complete denture - maxillary	$33.00
D5411	Adjust complete denture - mandibular	$33.00
D5421	Adjust partial denture - maxillary	$33.00
D5422	Adjust partial denture - mandibular	$33.00
D5511	Repair broken complete denture base, mandibular	$65.00
D5512	Repair broken complete denture base, maxillary	$65.00
D5520	Replace missing or broken teeth - complete denture - per tooth	$65.00
D5611	Repair resin partial denture base, mandibular	$65.00
D5612	Repair resin partial denture base, maxillary	$65.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$82.00

D5640	Replace missing or broken teeth - partial denture - per tooth	$65.00
D5650	Add tooth to existing partial denture - per tooth	$65.00
D5660	Add clasp to existing partial denture - per tooth	$82.00
D5710	Rebase complete maxillary denture	$195.00
D5711	Rebase complete mandibular denture	$195.00
D5720	Rebase maxillary partial denture	$195.00
D5721	Rebase mandibular partial denture	$195.00
D5725	Rebase hybrid prosthesis	$195.00
D5730	Reline complete maxillary denture (chairside)	$115.00
D5731	Reline complete mandibular denture (chairside)	$115.00
D5740	Reline maxillary partial denture (chairside)	$115.00
D5741	Reline mandibular partial denture (chairside)	$115.00
D5750	Reline complete maxillary denture (laboratory)	$170.00
D5751	Reline complete mandibular denture (laboratory)	$170.00
D5760	Reline maxillary partial denture (laboratory)	$170.00
D5761	Reline mandibular partial denture (laboratory)	$170.00
D5765	Soft liner for complete or partial removable denture - indirect	$170.00
D5810	Interim complete denture (maxillary)	$295.00
D5811	Interim complete denture (mandibular)	$295.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$235.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$235.00

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])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $130.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$460.00
D6211	Pontic - cast predominantly base metal	$405.00
D6212	Pontic - cast noble metal	$430.00
D6214	Pontic - titanium and titanium alloys	$460.00
D6240	Pontic - porcelain fused to high noble metal	$460.00
D6241	Pontic - porcelain fused to predominantly base metal	$405.00
D6242	Pontic - porcelain fused to noble metal	$430.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$430.00
D6245	Pontic - porcelain/ceramic	$450.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$460.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$460.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$405.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$405.00
D6606	Retainer inlay - cast noble metal, two surfaces	$430.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$430.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$460.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$460.00

D6612	Retainer onlay - cast predominantly base metal, two surfaces	$405.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$405.00
D6614	Retainer onlay - cast noble metal, two surfaces	$430.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$430.00
D6624	Retainer inlay - titanium	$460.00
D6634	Retainer onlay - titanium	$460.00
D6740	Retainer crown - porcelain/ceramic	$505.00
D6750	Retainer crown - porcelain fused to high noble metal	$460.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$405.00
D6752	Retainer crown - porcelain fused to noble metal	$430.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$460.00
D6780	Retainer crown - 3/4 cast high noble metal	$460.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$405.00
D6782	Retainer crown - 3/4 cast noble metal	$430.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$460.00
D6790	Retainer crown - full cast high noble metal	$460.00
D6791	Retainer crown - full cast predominantly base metal	$405.00
D6792	Retainer crown - full cast noble metal	$430.00
D6794	Retainer crown - titanium and titanium alloys	$460.00
D6930	Re-cement or re-bond fixed partial denture	$62.00

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	$50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$50.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$100.00
D7220	Removal of impacted tooth - soft tissue	$110.00
D7230	Removal of impacted tooth - partially bony	$145.00
D7240	Removal of impacted tooth - completely bony	$220.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220.00
D7250	Removal of residual tooth roots (cutting procedure)	$100.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$145.00
D7252	Partial extraction for immediate implant placement - *Once in a lifetime*	$100.00
D7260	Oroantral fistula closure	$315.00
D7261	Primary closure of sinus perforation	$315.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$155.00
D7280	Exposure of an unerupted tooth	$185.00
D7283	Placement of device to facilitate eruption of impacted tooth	$44.00
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	$120.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$155.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$120.00
D7287	Exfoliative cytological sample collection	$67.00
D7288	Brush biopsy - transepithelial sample collection	$67.00

D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$135.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$66.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$170.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$170.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$190.00
D7472	Removal of torus palatinus	$190.00
D7473	Removal of torus mandibularis	$190.00
D7485	Reduction of osseous tuberosity	$135.00
D7509	Marsupialization of odontogenic cyst	$170.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$66.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$100.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7963	Frenuloplasty	$17.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive 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:	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0322	Tomographic survey	
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	

	The Benefit for post-treatment records includes:	$70.00
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	
D0470	Diagnostic casts	
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$2,774.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$2,774.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$3,590.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children*	$3,590.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$61.00
D8670	Periodic orthodontic treatment visit	No Cost
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$345.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session and records*	$175.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	$45.00
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$73.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$73.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$73.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$73.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$70.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 24 months*	$255.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 24 months*	$255.00

D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 24 months*	$255.00
D9951	Occlusal adjustment, limited	$50.00
D9952	Occlusal adjustment, complete	$260.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$165.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be authorized by the Plan. The Enrollee pays the Copayment specified for such services. ***

* *Benefits may vary slightly based on state requirements and/or regulations.*

*** *Provisions regarding copayments and in and out-of-network treatment vary in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont. See below.*

Alaska and North Dakota Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Connecticut Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. Copayments apply for in-network treatment only. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Contract Fee for a covered service with a calendar year maximum of $500.00. Enrollees are responsible for the other 50 percent plus the difference between the out-of-network Dentist's fee and the Contract Fee, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Idaho Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the DeltaCare USA network.

Louisiana, Mississippi and North Carolina Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan is the fee actually charged by the out-of-network Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment. If the out-of-network Dentist's fee is greater than the Maximum Fee Allowance, the enrollee is responsible for the difference as well as the copayment. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Maine, New Hampshire and Vermont Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit paid by the Plan for out-of-network treatment is 80 percent of the fee charged by the Dentist or 80 percent of the Maximum Fee Allowance, whichever is lower, less the copayment. Enrollees are responsible for the copayments as well as the other 20 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Montana Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 75 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for the copayments as well as the other 25 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Oklahoma Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for

out-of-network treatment is 70 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for Copayments as well as the other 30 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

South Dakota Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments, as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental Premier network.

SCHEDULE B

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in the *Description of Benefits and Copayments.*

2. Fabrication of athletic mouthguard is limited to once every 24 months for patients 18 and younger.

3. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $130.00 above the listed Copayment for each of these services after the sixth unit has been provided.

4. 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).

   New Hampshire Only:

   General anesthesia and/or intravenous sedation/analgesia is limited to:

   a) treatment by an 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); or

   b) anesthesia administered by a licensed Dentist for dental procedures performed in a Dentist's office on a covered person who is:
      i) a child under the age of 6 who is determined by a licensed Dentist, in conjunction with a licensed physician, to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or
      ii) a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician, which places the person at serious risk.

5. Benefits provided by a pediatric Dentist are limited to children through age 13 and upon prior authorization by the Plan, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

6. Your cost for receiving orthodontic treatment when 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. You make payment directly to the Contract Orthodontist as arranged.

7. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. The Plan is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under the *Description of Benefits and Copayments. (Exclusion does not apply in South Dakota.)*

2. Any procedure that in the professional opinion of the Contract Dentist:

   * 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, except for the treatment of newborn children with congenital defects or birth abnormalities.

   Minnesota only:

   This exclusion does not apply to 1) the treatment of newborn children with congenital defects or birth abnormalities which result in a functional defect as determined by their attending physician; 2) dental treatment for the management of cleft lip or cleft palate when such treatment is scheduled or initiated prior to the dependent child turning age 19; or 3) dental reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part.

4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

   Minnesota only:

   This exclusion does not include covered services provided by a provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with Craniomandibular Disorder and myofacial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

7. 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.

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

9. Consultations for non-covered Benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage. *(Exclusion does not apply in Alaska, Connecticut, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota or Vermont.)*

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

12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your 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. Lost, stolen or broken orthodontic appliances.

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

16. Myofunctional and parafunctional appliances and/or therapies.

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

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

** Washington statutes require that carriers offer a TMJ Rider which covers certain TMJ procedures. This rider is available to groups with employees located in Washington and is available for Washington enrollees only. For additional information on the TMJ Rider, contact your broker and/or sales representative.

<u>Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont Only:</u>

In accordance with state regulatory requirements, DeltaCare USA is offered as an open access plan in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont.

Enrollees can obtain treatment from any licensed dentist or orthodontist. Unless it is specifically noted, all Limitations and Exclusions would apply to both "Contract" and "Non-Contracted" dentists and orthodontists.