

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. 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 the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2021 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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999 I. DIAGNOSTIC		
	<i>GP means General Practitioner.</i>	
	<i>SP means Specialty Care Practitioner.</i>	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused (GP)	No Cost
D0140	Limited oral evaluation - problem focused (SP)	\$12.00
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 (GP)	No Cost
D0150	Comprehensive oral evaluation - new or established patient (SP)	\$12.00
D0160	Detailed and extensive oral evaluation - problem focused, by report (GP)	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report (SP)	\$12.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient (GP)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient (SP)	\$12.00
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images	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	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost

D0330	Panoramic radiographic image	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	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
D0704	3-D photographic image - 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 - complete series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	\$10.00
D1354	Interim caries arresting medicament application - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$40.00
D1526	Space maintainer - removable - bilateral, maxillary	\$40.00
D1527	Space maintainer - removable - bilateral, mandibular	\$40.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant ...	\$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$10.00
D1557	Removal of fixed bilateral space maintainer - maxillary	\$10.00

D1558	Removal of fixed bilateral space maintainer - mandibular	\$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	\$40.00

D2000-D2999 III. RESTORATIVE

- Includes indirect pulp capping, bases, liners and acid etch procedures.

D2140	Amalgam - one surface, primary or permanent	\$4.00
D2150	Amalgam - two surfaces, primary or permanent	\$7.00
D2160	Amalgam - three surfaces, primary or permanent	\$10.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$12.00
D2330	Resin-based composite - one surface, anterior	\$10.00
D2331	Resin-based composite - two surfaces, anterior	\$15.00
D2332	Resin-based composite - three surfaces, anterior	\$20.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$25.00
D2390	Resin-based composite crown, anterior	\$35.00
D2391	Resin-based composite - one surface, posterior	Optional
D2392	Resin-based composite - two surfaces, posterior	Optional
D2393	Resin-based composite - three surfaces, posterior	Optional
D2394	Resin-based composite - four or more surfaces, posterior	Optional
D2410	Gold foil - one surface	Optional
D2420	Gold foil - two surfaces	Optional
D2430	Gold foil - three surfaces	Optional
D2510	Inlay - metallic - one surface ³	\$120.00
D2520	Inlay - metallic - two surfaces ³	\$130.00
D2530	Inlay - metallic - three or more surfaces ³	\$140.00
D2542	Onlay - metallic - two surfaces ³	\$136.00
D2543	Onlay - metallic - three surfaces ³	\$146.00
D2544	Onlay - metallic - four or more surfaces ³	\$152.00
D2610	Inlay - porcelain/ceramic - one surface	Optional
D2620	Inlay - porcelain/ceramic - two surfaces	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces	Optional
D2642	Onlay - porcelain/ceramic - two surfaces	Optional
D2643	Onlay - porcelain/ceramic - three surfaces	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces	Optional
D2650	Inlay - resin-based composite - one surface	Optional
D2651	Inlay - resin-based composite - two surfaces	Optional
D2652	Inlay - resin-based composite - three or more surfaces	Optional
D2662	Onlay - resin-based composite - two surfaces	Optional
D2663	Onlay - resin-based composite - three surfaces	Optional
D2664	Onlay - resin-based composite - four or more surfaces	Optional
D2710	Crown - resin-based composite (indirect) ¹	\$50.00
D2720	Crown - resin with high noble metal ^{1, 3}	\$180.00
D2721	Crown - resin with predominantly base metal ¹	\$180.00
D2722	Crown - resin with noble metal ¹	\$180.00
D2740	Crown - porcelain/ceramic ¹	\$180.00
D2750	Crown - porcelain fused to high noble metal ^{1, 3}	\$180.00
D2751	Crown - porcelain fused to predominantly base metal ¹	\$180.00
D2752	Crown - porcelain fused to noble metal ¹	\$180.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$180.00

D2780	Crown - 3/4 cast high noble metal ³	\$180.00
D2781	Crown - 3/4 cast predominantly base metal	\$180.00
D2782	Crown - 3/4 cast noble metal	\$180.00
D2783	Crown - 3/4 porcelain/ceramic ¹	\$180.00
D2790	Crown - full cast high noble metal ³	\$180.00
D2791	Crown - full cast predominantly base metal	\$180.00
D2792	Crown - full cast noble metal	\$180.00
D2794	Crown - titanium and titanium alloys ³	\$180.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$10.00
D2920	Re-cement or re-bond crown	\$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	\$25.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	\$35.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Optional
D2930	Prefabricated stainless steel crown - primary tooth	\$35.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$35.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$35.00
D2933	Prefabricated stainless steel crown with resin window	Optional
D2940	Protective restoration	\$5.00
D2941	Interim therapeutic restoration - primary dentition	\$5.00
D2949	Restorative foundation for an indirect restoration	\$15.00
D2950	Core buildup, including any pins when required	\$15.00
D2951	Pin retention - per tooth, in addition to restoration	\$15.00
D2952	Post and core in addition to crown, indirectly fabricated ³	\$15.00
D2953	Each additional indirectly fabricated post - same tooth ³	\$15.00
D2954	Prefabricated post and core in addition to crown	\$15.00
D2957	Each additional prefabricated post - same tooth	\$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$36.00
D2980	Crown repair necessitated by restorative material failure	\$20+lab
D2981	Inlay repair necessitated by restorative material failure	\$20+lab
D2982	Onlay repair necessitated by restorative material failure	\$20+lab
D2983	Veneer repair necessitated by restorative material failure	\$20+lab
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i>	\$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$5.00
D3221	Pulpal debridement, primary and permanent teeth	\$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$5.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$5.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$55.00

D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	\$110.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$165.00
D3331	Treatment of root canal obstruction; non-surgical access	\$55.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$55.00
D3346	Retreatment of previous root canal therapy - anterior	\$66.00
D3347	Retreatment of previous root canal therapy - premolar	\$132.00
D3348	Retreatment of previous root canal therapy - molar	\$200.00
D3410	Apicoectomy - anterior	\$85.00
D3421	Apicoectomy - premolar (first root)	\$85.00
D3425	Apicoectomy - molar (first root)	\$85.00
D3426	Apicoectomy (each additional root)	\$50.00
D3430	Retrograde filling - per root	\$50.00
D3471	Surgical repair of root resorption - anterior	\$85.00
D3472	Surgical repair of root resorption - premolar	\$85.00
D3473	Surgical repair of root resorption - molar	\$85.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$85.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$85.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	\$85.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$150.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$135.00
D4245	Apically positioned flap	\$135.00
D4249	Clinical crown lengthening - hard tissue	\$175.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$275.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$275.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$40.00

D4910	Periodontal maintenance	\$32.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary ⁴	\$225.00
D5120	Complete denture - mandibular ⁴	\$225.00
D5130	Immediate denture - maxillary ⁴	\$300.00
D5140	Immediate denture - mandibular ⁴	\$300.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) ⁴	\$250.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) ⁴	\$250.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ⁴	\$275.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ⁴	\$275.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$250.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$250.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$275.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$275.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) ⁴	Optional
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) ⁴	Optional
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary ..	\$250.00
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	\$250.00
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	\$250.00
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	\$250.00
D5410	Adjust complete denture - maxillary	\$10.00
D5411	Adjust complete denture - mandibular	\$10.00
D5421	Adjust partial denture - maxillary	\$10.00
D5422	Adjust partial denture - mandibular	\$10.00
D5511	Repair broken complete denture base, mandibular	\$25.00
D5512	Repair broken complete denture base, maxillary	\$25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$10.00
D5611	Repair resin partial denture base, mandibular	\$25.00
D5612	Repair resin partial denture base, maxillary	\$25.00
D5621	Repair cast partial framework, mandibular	\$25.00
D5622	Repair cast partial framework, maxillary	\$25.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$25.00
D5640	Replace broken teeth - per tooth	\$10.00

D5650	Add tooth to existing partial denture	\$10.00
D5660	Add clasp to existing partial denture - per tooth	\$10.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$150.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$150.00
D5710	Rebase complete maxillary denture	\$50.00
D5711	Rebase complete mandibular denture	\$50.00
D5720	Rebase maxillary partial denture	\$50.00
D5721	Rebase mandibular partial denture	\$50.00
D5730	Reline complete maxillary denture (chairside)	\$30.00
D5731	Reline complete mandibular denture (chairside)	\$30.00
D5740	Reline maxillary partial denture (chairside)	\$30.00
D5741	Reline mandibular partial denture (chairside)	\$30.00
D5750	Reline complete maxillary denture (laboratory)	\$50.00
D5751	Reline complete mandibular denture (laboratory)	\$50.00
D5760	Reline maxillary partial denture (laboratory)	\$50.00
D5761	Reline mandibular partial denture (laboratory)	\$50.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	No Cost
D5850	Tissue conditioning, maxillary	\$10.00
D5851	Tissue conditioning, mandibular	\$10.00
D5863	Overdenture - complete maxillary	Optional
D5864	Overdenture - partial maxillary	Optional
D5865	Overdenture - complete mandibular	Optional
D5866	Overdenture - partial mandibular	Optional

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])

D6210	Pontic - cast high noble metal ³	\$180.00
D6211	Pontic - cast predominantly base metal	\$180.00
D6212	Pontic - cast noble metal	\$180.00
D6240	Pontic - porcelain fused to high noble metal ^{1, 3}	\$180.00
D6241	Pontic - porcelain fused to predominantly base metal ¹	\$180.00
D6242	Pontic - porcelain fused to noble metal ¹	\$180.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$180.00
D6250	Pontic - resin with high noble metal ^{1, 3}	\$180.00
D6251	Pontic - resin with predominantly base metal ¹	\$180.00
D6252	Pontic - resin with noble metal ¹	\$180.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6549	Retainer - for resin bonded fixed prosthesis	Optional
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces ³	\$140.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces ³	\$140.00

D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$130.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$140.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$130.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$140.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces ³	\$146.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces ³	\$152.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$136.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$142.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$146.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$152.00
D6720	Retainer crown - resin with high noble metal ^{1, 3}	\$180.00
D6721	Retainer crown - resin with predominantly base metal ¹	\$180.00
D6722	Retainer crown - resin with noble metal ¹	\$180.00
D6750	Retainer crown - porcelain fused to high noble metal ^{1, 3}	\$180.00
D6751	Retainer crown - porcelain fused to predominantly base metal ¹	\$180.00
D6752	Retainer crown - porcelain fused to noble metal ¹	\$180.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$180.00
D6780	Retainer crown - 3/4 cast high noble metal ³	\$180.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$180.00
D6782	Retainer crown - 3/4 cast noble metal	\$180.00
D6784	Retainer crown - titanium and titanium alloys	\$180.00
D6790	Retainer crown - full cast high noble metal ³	\$180.00
D6791	Retainer crown - full cast predominantly base metal	\$180.00
D6792	Retainer crown - full cast noble metal	\$180.00
D6930	Re-cement or re-bond fixed partial denture	\$15.00
D6940	Stress breaker	\$25.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	\$6.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$6.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	\$50.00
D7230	Removal of impacted tooth - partially bony	\$70.00
D7240	Removal of impacted tooth - completely bony	\$90.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$90.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$90.00
D7286	Incisional biopsy of oral tissue-soft	\$20.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$50.00
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	\$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$50.00
D7472	Removal of torus palatinus	\$50.00
D7473	Removal of torus mandibularis	\$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	\$50.00
D7962	Lingual frenectomy (frenulectomy)	\$50.00

D8000-D8999 XI. ORTHODONTICS

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$200.00

D0210	Intraoral - complete series of radiographic images
D0322	Tomographic survey
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0350	2D oral/facial photographic images obtained intraorally or extraorally
D0351	3D photographic image
D0470	Diagnostic casts

The benefit for post-treatment records includes: \$70.00

D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8020	Limited orthodontic treatment of the transitional dentition ²	\$1,950.00
D8030	Limited orthodontic treatment of the adolescent dentition ²	\$1,950.00
D8040	Limited orthodontic treatment of the adult dentition ²	\$2,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition ²	\$1,950.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition ²	\$1,950.00
D8090	Comprehensive orthodontic treatment of the adult dentition ²	\$2,150.00
D8660	Pre-orthodontic treatment examination to monitor growth and development (<i>applied to treatment fee if patient proceeds with treatment</i>)	\$25.00
D8670	Periodic orthodontic treatment visit - <i>Inclusive of treatment fee</i>	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ²	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure ..	\$10.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost

D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$20.00
D9311	Consultation with a medical health care professional	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	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
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i>	\$10.00
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

Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are Benefits. "Filed fees" mean the Contract Dentist's fees on file with the Administrator. Questions regarding the DeltaCare USA Program should be directed to the Customer Service department at 800-422-4234.

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 Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

The Contract Dentist shall provide emergency dental care for a covered procedure which is required while an Enrollee is within 35 miles of the facility of the Contract Dentist. If an Enrollee requires emergency dental care and is more than 35 miles from the facility of the Contract Dentist, or is unable to reach the Contract Dentist, then Delta Dental shall reimburse the Enrollee for the cost of such emergency dental care which exceeds the Enrollee's Copayment. All services are subject to the limitations and exclusions of the program. Emergency dental care shall be limited to listed procedures and as described in code D9110 above: (Palliative (emergency) treatment of dental pain). Any further treatment of the cause of such emergency dental care must be authorized by Delta Dental or provided by the assigned Contract Dentist.

FOOTNOTES

- 1 *Porcelain on molars is considered optional treatment.*
- 2 *Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee, not to exceed \$75.00 per month.*
- 3 *Base or noble metal is the benefit. If high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.*
- 4 *Includes any adjustments for six months.*

SCHEDULE B

Limitations of Benefits

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance).
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.
5. Denture relines are limited to one per denture during any 12 consecutive months.
6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months.
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
8. Bitewing x-rays are limited to not more than one series of four films in any six month period.
9. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months.
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant.
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.
12. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist's usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment.

13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment.
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspid.
15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement.
16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth.
17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by the Administrator, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
18. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment.
19. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered procedure and Optional treatment, plus any Copayment for the covered procedure.
20. A Preexisting Condition is a disease or physical condition caused by illness or injury for which medical advice or treatment has been received within 90 days immediately prior to becoming eligible with the DeltaCare USA Program. Such condition shall be covered after the individual has been covered for more than 12 months under the group contract. Example: Teeth prepared for crowns, root canals in progress, orthodontic treatment.

Exclusions of Benefits

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.
2. Dental procedures performed for purely cosmetic purposes.
3. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.
4. Treatment required by reason of war, declared or undeclared.
5. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities.
7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
9. Any service that is not specifically listed in *Schedule A, Description of Benefits and Copayments*.
10. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function, except for medically diagnosed congenital defects or birth abnormalities in newborn children.
11. Cysts and malignancies.
12. Prescription drugs.
13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized by the Administrator or as cited under *Section 4.04 or Emergency Services*.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. "Consultations" for noncovered procedures.

17. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
18. Placement of a crown where there is sufficient tooth structure to retain a standard filling.
19. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
20. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
21. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).
22. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization.
23. Any part of a preventive or soft tissue management program, which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
24. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
25. Restorative work caused by orthodontic treatment.
26. Extractions solely for the purpose of orthodontics.
27. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
28. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Orthodontic Limitations

The Program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in *Schedule A, Description of Benefits and Copayments* subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.
3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed \$75.00 per month.
4. 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. In this event the Enrollee's obligation shall be based on the Contract Orthodontist's usual 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.
5. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee.
6. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
7. If an individual begins comprehensive orthodontic treatment within 90 days immediately prior to becoming eligible under the DeltaCare USA Program, a waiting period of 12 months of continuous coverage under the DeltaCare USA Program applies before coverage is available.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
2. Retreatment of orthodontic cases.
3. Surgical procedures incidental to orthodontic treatment.
4. Myofunctional therapy.
5. Surgical procedures related to cleft palate, micrognathia or macrognathia.
6. Treatment related to temporomandibular joint disturbances.
7. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.
8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed \$75.00 per month.
9. Restorative work caused by orthodontic treatment.
10. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
11. Extractions solely for the purpose of orthodontics.
12. Patient initiated transfer after bands have been placed.
13. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.