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 CDT-2007 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association 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
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
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
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 - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1203	Topical application of fluoride (prophylaxis not included) - child - *to age 19; 1 per 6 month period*	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - *child to age 19; 1 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1510	Space maintainer - fixed - unilateral	$40.00
D1515	Space maintainer - fixed - bilateral	$40.00
D1520	Space maintainer - removable - unilateral	$50.00
D1525	Space maintainer - removable - bilateral	$50.00
D1550	Re-cementation of space maintainer	$10.00
D1555	Removal of fixed space maintainer	$10.00

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 $100.00 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	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00

D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00
D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - ¾ resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic substrate	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2780	Crown - ¾ cast high noble metal	$355.00
D2781	Crown - ¾ cast predominantly base metal	$255.00
D2782	Crown - ¾ cast noble metal	$295.00
D2783	Crown - ¾ porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium	$355.00
D2910	Recement inlay, onlay or partial coverage restoration	$10.00
D2915	Recement cast or prefabricated post and core	$10.00
D2920	Recement crown	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	$10.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair, by report	$20.00

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	$25.00
D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - anterior (excluding final restoration)	$95.00
D3320	*Root canal* - bicuspid (excluding final restoration)	$185.00
D3330	*Root canal* - molar (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - bicuspid	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy/periradicular surgery - anterior	$115.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$125.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$135.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$80.00
D3430	Retrograde filling - per root	$60.00
D3450	Root amputation, per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

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 bounded teeth spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$300.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$240.00

D4263	Bone replacement graft - first site in quadrant	$215.00
D4264	Bone replacement graft - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$215.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00

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. 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.
- 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	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$245.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
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
D5510	Repair broken complete denture base	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5610	Repair resin denture base	$40.00
D5620	Repair cast framework	$40.00
D5630	Repair or replace broken clasp	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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 $100.00 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	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Inlay - cast high noble metal, two surfaces	$255.00
D6603	Inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Inlay - cast noble metal, two surfaces	$185.00
D6607	Inlay - cast noble metal, three or more surfaces	$195.00
D6608	Onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Onlay - cast high noble metal, two surfaces	$260.00
D6611	Onlay - cast high noble metal, three or more surfaces	$270.00

D6612	Onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Onlay - cast noble metal, two surfaces	$190.00
D6615	Onlay - cast noble metal, three or more surfaces	$200.00
D6720	Crown - resin with high noble metal	$295.00
D6721	Crown - resin with predominantly base metal	$195.00
D6722	Crown - resin with noble metal	$235.00
D6740	Crown - porcelain/ceramic	$355.00
D6750	Crown - porcelain fused to high noble metal	$355.00
D6751	Crown - porcelain fused to predominantly base metal	$255.00
D6752	Crown - porcelain fused to noble metal	$295.00
D6780	Crown - ¾ cast high noble metal	$355.00
D6781	Crown - ¾ cast predominantly base metal	$255.00
D6782	Crown - ¾ cast noble metal	$295.00
D6783	Crown - ¾ porcelain/ceramic	$355.00
D6790	Crown - full cast high noble metal	$355.00
D6791	Crown - full cast predominantly base metal	$255.00
D6792	Crown - full cast noble metal	$295.00
D6930	Recement fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation*	$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation*	$80.00
D6973	Core buildup for retainer, including any pins	$50.00
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D6980	Fixed partial denture repair, by report	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Surgical access of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
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
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
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
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

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:	$200.00
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series (including bitewings)	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$1,150.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,150.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,150.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,350.00
D8050	Interceptive orthodontic treatment of the primary dentition	$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,900.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,900.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,100.00

D8660	Pre-orthodontic treatment visit	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

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	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes	$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$80.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$165.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$10.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9972	External bleaching - per arch - *limited to one bleaching tray and gel for two weeks of self treatment*	$125.00
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time* **	$10.00

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. ***

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with the Plan. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

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

*** Not applicable in Texas or Washington*

**** Provisions regarding copayments and in and out-of-network treatment vary in Alaska, Connecticut, Louisiana, Mississippi, Oklahoma and South Dakota. See below.*

Alaska 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 copayment 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 www.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 *www.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.

Louisiana and Mississippi 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 *www.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 the 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 www.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 copayment, 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 www.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 of Benefits

Limitations

1. The frequency of certain Benefits is limited. All 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 $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

   Washington Only

   This limitation does not apply if general anesthesia services are medically necessary because the Enrollee is under age seven or is physically or developmentally disabled.

4. 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 Plan, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

5. 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 usual 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.

   Maryland Only:

   Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving 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, Alpha will continue to provide orthodontic Benefits for:

   - 60 days if the Enrollee is making monthly payments to the Contract Orthodontist, or
   - until the later of 60 days 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 will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

6. 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.

   Pennsylvania Only:

   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.

   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.

* *Frequency limitations on diagnostic and preventive procedures do not apply in Texas when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

Exclusions of Benefits

Exclusions

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

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

   a. has 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 generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9972, External bleaching, 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.

   South Carolina Only:

   This exclusion does not apply to, teeth capping, prosthodontics, and orthodontics necessary for the treatment of congenital cleft lip or cleft palate.

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

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

   Washington Only

   This exclusion does not apply to dental services specifically covered under a TMJ Rider **

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.

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 the Enrollee's eligibility with the DeltaCare USA program. 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 and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a 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.

Exclusion number 1 does not apply in South Dakota.

Exclusion number 10 does not apply in Alaska, Connecticut, Louisiana, Mississippi, Oklahoma or South Dakota.

Exclusion number 13 does not apply in Pennsylvania.

Exclusion number 18 does not apply in Maryland.

Alaska, Connecticut, Louisiana, Mississippi, Oklahoma and South Dakota Only:
In accordance with state regulatory requirements, DeltaCare USA is offered as an open access plan in Alaska, Connecticut, Louisiana, Mississippi, Oklahoma and South Dakota. 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.