

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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
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 <i>radiographs</i> - complete series (including bitewings) - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing <i>radiograph</i> - single film	No Cost
D0272	Bitewings <i>radiographs</i> - two films	No Cost
D0273	Bitewings <i>radiographs</i> - three films	No Cost
D0274	Bitewings <i>radiographs</i> - four films - <i>limited to 1 series every 6 months</i>	No Cost
D0330	Panoramic film	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 - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis <i>cleaning</i> - adult - 1 per 6 month period	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - 1 per 6 month period	No Cost
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
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cementation of space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost

D2000-D2999 III. RESTORATIVE

Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

D2140	Amalgam - one surface, primary or permanent	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)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior ^{1, 2}	Optional
D2392	Resin-based composite - two surfaces, posterior ^{1, 2}	Optional
D2393	Resin-based composite - three surfaces, posterior ^{1, 2}	Optional
D2394	Resin-based composite - four or more surfaces, posterior ^{1, 2}	Optional
D2510	Inlay - metallic - one surface ^{3, 4}	No Cost
D2520	Inlay - metallic - two surfaces ^{3, 4}	No Cost
D2530	Inlay - metallic - three or more surfaces ^{3, 4}	No Cost
D2542	Onlay - metallic - two surfaces ^{3, 4}	No Cost
D2543	Onlay - metallic - three surfaces ^{3, 4}	No Cost
D2544	Onlay - metallic - four or more surfaces ^{3, 4}	No Cost
D2610	Inlay - porcelain/ceramic - one surface ^{1, 4}	Optional
D2620	Inlay - porcelain/ceramic - two surfaces ^{1, 4}	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces ^{1, 4}	Optional
D2642	Onlay - porcelain/ceramic - two surfaces ^{1, 4}	Optional
D2643	Onlay - porcelain/ceramic - three surfaces ^{1, 4}	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces ^{1, 4}	Optional
D2650	Inlay - resin-based composite - one surface ^{1, 4}	Optional
D2651	Inlay - resin-based composite - two surfaces ^{1, 4}	Optional
D2652	Inlay - resin-based composite - three or more surfaces ^{1, 4}	Optional
D2662	Onlay - resin-based composite - two surfaces ^{1, 4}	Optional

D2663	Onlay - resin-based composite - three surfaces ^{1, 4}	Optional
D2664	Onlay - resin-based composite - four or more surfaces ^{1, 4}	Optional
D2710	Crown - resin-based composite (indirect) ^{4, 5}	No Cost
D2712	Crown - ¾ resin-based composite (indirect) ^{4, 5}	No Cost
D2720	Crown - resin with high noble metal ^{3, 4, 5}	No Cost
D2721	Crown - resin with predominantly base metal ^{4, 5}	No Cost
D2722	Crown - resin with noble metal ^{4, 5}	No Cost
D2740	Crown - porcelain/ceramic substrate ^{4, 5}	No Cost
D2750	Crown - porcelain fused to high noble metal ^{3, 4, 5}	No Cost
D2751	Crown - porcelain fused to predominantly base metal ^{4, 5}	No Cost
D2752	Crown - porcelain fused to noble metal ^{4, 5}	No Cost
D2780	Crown - ¾ cast high noble metal ^{3, 4}	No Cost
D2781	Crown - ¾ cast predominantly base metal ⁴	No Cost
D2782	Crown - ¾ cast noble metal ⁴	No Cost
D2790	Crown - full cast high noble metal ^{3, 4}	No Cost
D2791	Crown - full cast predominantly base metal ⁴	No Cost
D2792	Crown - full cast noble metal ⁴	No Cost
D2794	Crown - titanium ^{3, 4}	No Cost
D2910	Recent inlay, onlay or partial coverage restoration	No Cost
D2915	Recent cast or prefabricated post and core	No Cost
D2920	Recent crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ³	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ³	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	No Cost
D2980	Crown repair, by report	No Cost

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	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - anterior (excluding final restoration) ⁶	No Cost
D3320	Root canal - bicuspid (excluding final restoration) ⁶	No Cost

D3330	Root canal - molar (excluding final restoration) ⁶	No Cost
D3346	Retreatment of previous root canal therapy - anterior ⁶	No Cost
D3347	Retreatment of previous root canal therapy - bicuspid ⁶	No Cost
D3348	Retreatment of previous root canal therapy - molar ⁶	No Cost
D3410	Apicoectomy/periradicular surgery - anterior ⁶	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) ⁶	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root) ⁶	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root) ⁶	No Cost
D3430	Retrograde filling - per root ⁶	No Cost
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i> ⁶	No Cost

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	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary ^{7,8}	No Cost
D5120	Complete denture - mandibular ^{7,8}	No Cost
D5130	Immediate denture - maxillary ^{7,8}	No Cost
D5140	Immediate denture - mandibular ^{7,8}	No Cost
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ^{7,8}	No Cost
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ^{7,8}	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{7,8}	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{7,8}	No Cost
D5410	Adjust complete denture - maxillary ⁷	No Cost
D5411	Adjust complete denture - mandibular ⁷	No Cost
D5421	Adjust partial denture - maxillary ⁷	No Cost
D5422	Adjust partial denture - mandibular ⁷	No Cost

D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture	No Cost
D5710	Rebase complete maxillary denture ⁹	No Cost
D5711	Rebase complete mandibular denture ⁹	No Cost
D5720	Rebase maxillary partial denture ⁹	No Cost
D5721	Rebase mandibular partial denture ⁹	No Cost
D5730	Reline complete maxillary denture (chairside) ⁹	No Cost
D5731	Reline complete mandibular denture (chairside) ⁹	No Cost
D5740	Reline maxillary partial denture (chairside) ⁹	No Cost
D5741	Reline mandibular partial denture (chairside) ⁹	No Cost
D5750	Reline complete maxillary denture (laboratory) ⁹	No Cost
D5751	Reline complete mandibular denture (laboratory) ⁹	No Cost
D5760	Reline maxillary partial denture (laboratory) ⁹	No Cost
D5761	Reline mandibular partial denture (laboratory) ⁹	No Cost
D5820	Interim partial denture (maxillary) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i> ⁷	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i> ⁷	No Cost
D5850	Tissue conditioning, maxillary ^{7,9}	No Cost
D5851	Tissue conditioning, mandibular ^{7,9}	No Cost

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 ^{3,10}	No Cost
D6211	Pontic - cast predominantly base metal ¹⁰	No Cost
D6212	Pontic - cast noble metal ¹⁰	No Cost
D6240	Pontic - porcelain fused to high noble metal ^{3,5,10}	No Cost
D6241	Pontic - porcelain fused to predominantly base metal ^{5,10}	No Cost
D6242	Pontic - porcelain fused to noble metal ^{5,10}	No Cost
D6245	Pontic - porcelain/ceramic ^{1,10}	Optional
D6250	Pontic - resin with high noble metal ^{3,5,10}	No Cost
D6251	Pontic - resin with predominantly base metal ^{5,10}	No Cost
D6252	Pontic - resin with noble metal ^{5,10}	No Cost
D6600	Inlay - porcelain/ceramic, two surfaces ^{1,10}	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces ^{1,10}	Optional
D6602	Inlay - cast high noble metal, two surfaces ^{3,10}	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces ^{3,10}	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces ¹⁰	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces ¹⁰	No Cost
D6606	Inlay - cast noble metal, two surfaces ¹⁰	No Cost

D6607	Inlay - cast noble metal, three or more surfaces ¹⁰	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces ^{1, 10}	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces ^{1, 10}	Optional
D6610	Onlay - cast high noble metal, two surfaces ^{3, 10}	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces ^{3, 10}	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces ¹⁰	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces ¹⁰	No Cost
D6614	Onlay - cast noble metal, two surfaces ¹⁰	No Cost
D6615	Onlay - cast noble metal, three or more surfaces ¹⁰	No Cost
D6720	Crown - resin with high noble metal ^{3, 5, 10}	No Cost
D6721	Crown - resin with predominantly base metal ^{5, 10}	No Cost
D6722	Crown - resin with noble metal ^{5, 10}	No Cost
D6740	Crown - porcelain/ceramic ^{1, 10}	Optional
D6750	Crown - porcelain fused to high noble metal ^{3, 5, 10}	No Cost
D6751	Crown - porcelain fused to predominantly base metal ^{5, 10}	No Cost
D6752	Crown - porcelain fused to noble metal ^{5, 10}	No Cost
D6780	Crown - ¾ cast high noble metal ^{3, 10}	No Cost
D6781	Crown - ¾ cast predominantly base metal ¹⁰	No Cost
D6782	Crown - ¾ cast noble metal ¹⁰	No Cost
D6790	Crown - full cast high noble metal ^{3, 10}	No Cost
D6791	Crown - full cast predominantly base metal ¹⁰	No Cost
D6792	Crown - full cast noble metal ¹⁰	No Cost
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker ¹⁰	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i> ³	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i> ³	No Cost
D6973	Core buildup for retainer, including any pins	No Cost
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ³	No Cost
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D6980	Fixed partial denture repair, by report	No Cost

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)	No Cost
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7286	Biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost

D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ¹¹	\$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ¹¹	\$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> ¹¹	\$1,800.00
D8660	Pre-orthodontic treatment visit - <i>not to be charged with any other consultation procedure(s)</i> ¹²	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) ¹³	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9940	Occlusal guard, by report - <i>limited to bruxism (grinding), one every three years</i>	\$100.00
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00

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 PMI. Questions regarding these fees should be directed to PMI's Customer Service department at (800) 422-4234.

FOOTNOTES

- ¹ *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" means the Contract Dentist's fees on file with PMI. Questions regarding the DeltaCare USA program should be directed to PMI's Customer Service department at (800) 422-4234.*
- ² *An amalgam is the benefit.*
- ³ *Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of \$100.00 per tooth. This charge also applies to a titanium crown. If an indirectly fabricated post and core is made of high noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgraded post and core.*
- ⁴ *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*
- ⁵ *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150.00.*
- ⁶ *A benefit for permanent teeth only.*
- ⁷ *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*
- ⁸ *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*
- ⁹ *Limited to 1 per denture during any 12 consecutive months.*
- ¹⁰ *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*
- ¹¹ *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of \$75.00 applies.*
- ¹² *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*
- ¹³ *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$75.00 applies.*

SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. If a biopsy is preauthorized by PMI for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is \$100.00 per tooth or pontic. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is \$100.00 per tooth.
10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is \$150.00 per molar.
11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is \$75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
 - a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
 - b. Either of the following:
 - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**

- If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
 14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
 15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
 16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
 17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
 18. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
 - a. Fixed partial denture (bridge):
 - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
 - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics (see Limitation #12) **or**
 - Each abutment tooth to be crowned meets Limitation #8.
 - b. Removable partial denture:
 - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
 - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #12).
 19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
 20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
 - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
 - The replacement of permanent tooth/teeth for children under 16 years of age.
 21. Retained primary teeth shall be covered as primary teeth.
 22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
 23. 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 prior authorization by PMI, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

24. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits*.
25. Soft tissue management programs are limited to periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered services.
26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
27. An Optional procedure 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.

"Filed fees" means the Contract Dentist's fees on file with PMI. Questions regarding these fees should be directed to PMI's Customer Service department at (800) 422-4234.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is paid. 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, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist or the dental consultant:
 - 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.
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by PMI or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call PMI's Customer Service department at (800) 422-4234.
11. Consultations for non-covered benefits.
12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

15. 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).
16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services.
17. 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.
18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed \$75.00 per month.
4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not PMI will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300.00 for covered dependent children to age 19 and \$2,500.00 for covered adults and dependent children to age 23. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25 in addition to diagnostic record fees.
6. 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 and customary fee.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics, 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.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

Accident Injury Benefit

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

PMI will pay up to 100 percent of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of \$1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of \$1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.
4. Orthodontic services (treatment of malalignment of teeth and/or jaws).
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" means the Contract Dentist's fees on file with PMI. Questions regarding these fees should be directed to PMI's Customer Service department at (800) 422-4234.