

SCHEDULE A

DESCRIPTION OF BENEFITS AND COPAYMENTS *

PLAN 1A4

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 *Schedules B, C, D and E* for further clarification of benefits.

Codes and/or text that appear in italics below are specifically intended to clarify the delivery of benefits under the DeltaCare program and are not to be interpreted as CDT-4 procedure codes, descriptors or nomenclature which are under copyright by the American Dental Association.

Code	Description	ENROLLEE <u>PAYS</u>
D0100-D0999 I. Diagnostic		
D0120	Periodic oral evaluation	No Cost
D0140	Limited oral evaluation - problem focused.....	No Cost(GP)/ \$12.00(SP)
D0150	Comprehensive oral evaluation - new or established patient.....	No Cost(GP)/ \$12.00(SP)
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost(GP)/ \$12.00(SP)
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient.....	No Cost(GP)/ \$12.00(SP)
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings)	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 - single film	No Cost
D0272	Bitewings - two films	No Cost
D0274	Bitewings - four films.....	No Cost
D0277	Vertical bitewings - 7 to 8 films.....	No Cost
D0330	Panoramic film.....	No Cost
D0460	Pulp vitality tests.....	No Cost
D0470	Diagnostic casts	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 per 6 month period</i>	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	No Cost
D1201	Topical application of fluoride (including prophylaxis) - child - <i>to age 19; 1 per 6 month period</i>	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child - <i>to age 19; 1 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions.....	No Cost
D1351	Sealant - per tooth.....	\$ 10.00
D1510	Space maintainer - fixed - unilateral.....	\$ 40.00

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

Code	Description	
D1515	Space maintainer - fixed - bilateral.....	\$ 40.00
D1520	Space maintainer - removable - unilateral.....	\$ 40.00
D1525	Space maintainer - removable - bilateral.....	\$ 40.00
D1550	Recementation of space maintainer.....	\$ 10.00

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 *.....	\$120.00
D2520	Inlay - metallic - two surfaces *.....	\$130.00
D2530	Inlay - metallic - three or more surfaces *.....	\$140.00
D2542	Onlay - metallic - two surfaces *.....	\$136.00
D2543	Onlay - metallic - three surfaces *.....	\$146.00
D2544	Onlay - metallic - four or more surfaces *.....	\$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 (indirect) †.....	\$ 50.00
D2720	Crown - resin with high noble metal *†.....	\$180.00
D2721	Crown - resin with predominantly base metal †.....	\$180.00
D2722	Crown - resin with noble metal †.....	\$180.00
D2740	Crown - porcelain/ceramic substrate †.....	\$180.00
D2750	Crown - porcelain fused to high noble metal *†.....	\$180.00
D2751	Crown - porcelain fused to predominantly base metal †.....	\$180.00
D2752	Crown - porcelain fused to noble metal †.....	\$180.00
D2780	Crown - ¾ cast high noble metal *.....	\$180.00
D2781	Crown - ¾ cast predominantly base metal.....	\$180.00
D2782	Crown - ¾ cast noble metal.....	\$180.00
D2783	Crown - ¾ porcelain/ceramic †.....	\$180.00
D2790	Crown - full cast high noble metal *.....	\$180.00
D2791	Crown - full cast predominantly base metal.....	\$180.00
D2792	Crown - full cast noble metal.....	\$180.00
D2910	Recement inlay.....	\$ 10.00
D2920	Recement crown.....	\$ 10.00

Code	Description	
D2930	Prefabricated stainless steel crown - primary tooth.....	\$ 35.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$ 35.00
D2932	Prefabricated resin crown - <i>anterior teeth only</i>	\$ 35.00
D2933	Prefabricated stainless steel crown with resin window	Optional
D2940	Sedative filling.....	\$ 5.00
D2950	Core buildup, including any pins.....	\$ 15.00
D2951	Pin retention - per tooth, in addition to restoration.....	\$ 15.00
D2952	Cast post and core in addition to crown *.....	\$ 15.00
D2953	Each additional cast post - same tooth *	\$ 15.00
D2954	Prefabricated post and core in addition to crown	\$ 15.00
D2957	Each additional prefabricated post - same tooth.....	\$ 15.00
D2970	Temporary crown (fractured tooth)	No Cost
D2980	Crown repair, by report.....	\$20 + lab

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
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> - anterior (excluding final restoration)	\$ 55.00
D3320	<i>Root canal</i> - bicuspid (excluding final restoration)	\$110.00
D3330	<i>Root canal</i> - molar (excluding final restoration)	\$165.00
D3346	Retreatment of previous root canal therapy - anterior.....	\$ 66.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	\$132.00
D3348	Retreatment of previous root canal therapy - molar	\$200.00
D3410	Apicoectomy/periradicular surgery - anterior.....	\$ 85.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$ 85.00
D3425	Apicoectomy/periradicular surgery - molar (first root).....	\$ 85.00
D3426	Apicoectomy/periradicular surgery (each additional root)	\$ 50.00
D3430	Retrograde filling - per root	\$ 50.00

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.....	\$150.00
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	\$150.00
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 teeth, per quadrant.....	\$135.00
D4245	Apically positional flap	\$135.00
D4249	Clinical crown lengthening - hard tissue	\$175.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.....	\$275.00
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant.....	\$275.00
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces per quadrant.....	\$ 40.00
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant.....	\$ 40.00

Code	Description	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$ 40.00
D4910	Periodontal maintenance	\$ 32.00
D5000-D5899 VI. Prosthodontics (removable)		
D5110	Complete denture - maxillary **	\$225.00
D5120	Complete denture - mandibular **	\$225.00
D5130	Immediate denture - maxillary **	\$300.00
D5140	Immediate denture - mandibular **	\$300.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) **	\$250.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) **	\$250.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) **	\$275.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) **	\$275.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$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
D5510	Repair broken complete denture base	\$ 25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$ 10.00
D5610	Repair resin denture base	\$ 25.00
D5620	Repair cast framework	\$ 25.00
D5630	Repair or replace broken clasp	\$ 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	\$ 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 (maxillary)	No Cost
D5821	Interim partial denture (mandibular)	No Cost
D5850	Tissue conditioning, maxillary	\$ 10.00
D5851	Tissue conditioning, mandibular	\$ 10.00
D5860	Overdenture - complete, by report	Optional
D5861	Overdenture - partial, by report	Optional

** Includes any adjustments for six months.

D5900-D5999 VII. Maxillofacial Prosthetics - Not Covered

D6000-D6199 VIII. Implant Services - Not Covered

Code	Description	
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 *	\$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 *†	\$180.00
D6241	Pontic - porcelain fused to predominantly base metal †	\$180.00
D6242	Pontic - porcelain fused to noble metal †	\$180.00
D6250	Pontic - resin with high noble metal *†	\$180.00
D6251	Pontic - resin with predominantly base metal †	\$180.00
D6252	Pontic - resin with noble metal †	\$180.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6600	Inlay - porcelain/ceramic, two surfaces	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Inlay - cast high noble metal, two surfaces *	\$140.00
D6603	Inlay - cast high noble metal, three or more surfaces *	\$140.00
D6604	Inlay - cast predominantly base metal, two surfaces	\$130.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$140.00
D6606	Inlay - cast noble metal, two surfaces	\$130.00
D6607	Inlay - cast noble metal, three or more surfaces	\$140.00
D6608	Onlay - porcelain/ceramic, two surfaces	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Onlay - cast high noble metal, two surfaces *	\$146.00
D6611	Onlay - cast high noble metal, three or more surfaces *	\$152.00
D6612	Onlay - cast predominantly base metal, two surfaces	\$136.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$142.00
D6614	Onlay - cast noble metal, two surfaces	\$146.00
D6615	Onlay - cast noble metal, three or more surfaces	\$152.00
D6720	Crown - resin with high noble metal *†	\$180.00
D6721	Crown - resin with predominantly base metal †	\$180.00
D6722	Crown - resin with noble metal †	\$180.00
D6750	Crown - porcelain fused to high noble metal *†	\$180.00
D6751	Crown - porcelain fused to predominantly base metal †	\$180.00
D6752	Crown - porcelain fused to noble metal †	\$180.00
D6780	Crown - 3/4 cast high noble metal *	\$180.00
D6781	Crown - 3/4 cast predominantly base metal	\$180.00
D6782	Crown - 3/4 cast noble metal	\$180.00
D6790	Crown - full cast high noble metal *	\$180.00
D6791	Crown - full cast predominantly base metal	\$180.00
D6792	Crown - full cast noble metal	\$180.00
D6930	Recement fixed partial denture	\$ 15.00
D6940	Stress breaker	\$ 25.00
D6970	Cast post and core in addition to fixed partial denture retainer *	\$ 25.00
D6971	Cast post as part of fixed partial denture retainer *	\$ 25.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$ 15.00
D6973	Core buildup for retainer, including any pins	\$ 15.00
D6976	Each additional cast post - same tooth *	\$ 15.00
D6977	Each additional prefabricated post - same tooth	\$ 15.00

* Base or noble metal is the Benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast post and cores, inlays and onlays.
† Porcelain on molars is considered optional treatment.

Code	Description	
D7000-D7999 X. Oral and Maxillofacial Surgery		
<i>Includes preoperative and postoperative evaluations and treatment under local anesthetic.</i>		
D7111	Coronal remnants - deciduous teeth.....	\$ 6.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$ 6.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.....	\$ 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	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7286	Biopsy of oral tissue - soft (all others).....	\$ 20.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.....	\$ 50.00
D7320	Alveoloplasty not in conjunction with extractions - 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
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	\$ 50.00

D8000-D8999 XI. Orthodontics

Records solely for the purpose of Orthodontics include pre- and post records as follows:

	<i>Pre-records include the following:</i>	\$200.00
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial images (includes intra and extraoral images)	
D0470	Diagnostic casts	
	<i>Post Records include the following:</i>	\$ 70.00
D0210	Intraoral - complete series (including bitewings)	
D0470	Diagnostic casts	
D8020	Limited orthodontic treatment of the transitional dentition ***	\$1,950.00
D8030	Limited orthodontic treatment of the adolescent dentition ***	\$1,950.00
D8040	Limited orthodontic treatment of the adult dentition ***.....	\$2,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition ***.....	\$1,950.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition ***.....	\$1,950.00
D8090	Comprehensive orthodontic treatment of the adult dentition ***.....	\$2,150.00
D8660	Pre-orthodontic treatment visit (<i>applied to treatment fee if patient proceeds with treatment</i>).....	\$ 25.00
D8670	Periodic orthodontic treatment visit (as part of contract).....	Inclusive of treatment fee
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ***	No Cost

*** 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 per month.

Code	Description	
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
D9310	Consultation (diagnostic service provided by a dentist or physician other than practitioner providing treatment)	\$ 20.00
D9440	Office visit - after regularly scheduled hours	\$ 20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment without 24 hour notice - per 15 minutes of appointment time.....</i>	\$ 10.00

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 PMI. Questions regarding the DeltaCare program should be directed to PMI's Customer Relations 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 specialized services, and are referred by the assigned Contract Dentist, must be preauthorized in writing by PMI. 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".

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, then PMI shall reimburse the Enrollee for the cost of such emergency dental care which exceeds the Enrollee's Copayment up to a \$100 maximum per any 12-month period. 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 preauthorized by PMI or provided by the assigned Contract Dentist.

SCHEDULE B

LIMITATIONS OF BENEFITS

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);¹
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. Crown(s) 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;¹
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;¹
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;²
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;

¹ Frequency limitations do not apply in **Texas** when services are needed more frequently due to medical necessity as determined by the Contract Dentist.

² Limitation No. 10 is not applicable in **Texas**.

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 bicuspids;
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 prior authorization by PMI, 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. 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 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.

¹ Frequency limitations do not apply in **Texas** when services are needed more frequently due to medical necessity as determined by the Contract Dentist.

² Limitation No. 10 is not applicable in **Texas**.

SCHEDULE C

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
3. Dental conditions arising out of and due to Enrollee's employment for which Worker's 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;

New York and Pennsylvania only:

Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Enrollee's immediate family; and services for which no charge is normally made;

4. Treatment required by reason of war, declared or undeclared;⁴
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 or dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
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 (unless mandated by state law);⁵

³ *Exclusion No. 2 does not apply in **New York**.*

⁴ *Exclusion No. 4 does not apply in **California**.*

⁵ *Exclusion No. 10 does not apply in **New York**.*

⁶ *Exclusion No. 13 does not apply in **New York, Maryland, Texas, Washington DC or Pennsylvania**.*

11. Cysts and malignancies;
12. Prescription drugs;
13. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of Benefits;⁶
14. 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;
15. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by PMI or as cited under *Emergency Services*;
16. Prophylactic removal of impactions (asymptomatic, nonpathological);
17. “Consultations” for noncovered procedures;
18. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
19. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
20. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
21. 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);
22. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
23. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
24. Soft tissue management (irrigation, infusion, special toothbrush);
25. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
26. Restorative work caused by orthodontic treatment;

³ *Exclusion No. 2 does not apply in **New York**.*

⁴ *Exclusion No. 4 does not apply in **California**.*

⁵ *Exclusion No. 10 does not apply in **New York**.*

⁶ *Exclusion No. 13 does not apply in **New York, Maryland, Texas, Washington DC or Pennsylvania**.*

27. Extractions solely for the purpose of orthodontics.

28. Texas Only:

Charges by the Contract Dentist for broken or missed appointments not reported within 24 hours.

28. Maryland Only:

Specialist or orthodontic treatment resulting from a prohibited referral. A prohibited referral is when the Contract Dentist directs an Enrollee to seek specialist or orthodontic care from another dental facility where: i) the Contract Dentist owns a beneficial interest in the practice; ii) the Contract Dentist's immediate family owns a beneficial interest of 3 percent or greater in the practice; or iii) the Contract Dentist, the Contract Dentist's immediate family or a combination of the Contract Dentist and his or her immediate family has a compensation arrangement with the practice.

³ *Exclusion No. 2 does not apply in **New York**.*

⁴ *Exclusion No. 4 does not apply in **California**.*

⁵ *Exclusion No. 10 does not apply in **New York**.*

⁶ *Exclusion No. 13 does not apply in **New York, Maryland, Texas, Washington DC or Pennsylvania**.*

SCHEDULE D

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 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. 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 \$25.00 in addition to diagnostic record fees;⁷
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 fee;
7. 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.
8. Pennsylvania Only:

If an individual begins comprehensive orthodontic treatment within 90 days immediately prior to becoming eligible under the DeltaCare Program, a provision for treatment in progress is available subject to a waiting period of 12 months of continuous coverage under the DeltaCare Program.

⁷ *Orthodontic Limitation No. 5 does not apply in New York, Maryland, Washington DC or Pennsylvania.*

SCHEDULE E

ORTHODONTIC EXCLUSIONS

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation;⁸
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;
9. 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;
10. Restorative work caused by orthodontic treatment;
11. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
12. Extractions solely for the purpose of orthodontics;
13. Treatment in progress at inception of eligibility;
14. Patient initiated transfer after bands have been placed;
15. Composite or ceramic brackets, lingual adaptation of orthodontic and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

⁸ *Orthodontic Exclusion No. 3 does not apply in New York, Maryland, Washington DC or Pennsylvania.*