SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as needed and deemed necessary 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 DHMO Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2021 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	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
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0704	3-D photographic image - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - complete series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	$15.00
D1330	Oral hygiene instructions	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$100.00
D1516	Space maintainer - fixed - bilateral, maxillary	$150.00
D1517	Space maintainer - fixed - bilateral, mandibular	$150.00
D1520	Space maintainer - removable - unilateral - per quadrant	$100.00
D1526	Space maintainer - removable - bilateral, maxillary	$150.00
D1527	Space maintainer - removable - bilateral, mandibular	$150.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$100.00

D2000-D2999 III. RESTORATIVE

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

**Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*

D2140	Amalgam - one surface, primary or permanent	$27.00
D2150	Amalgam - two surfaces, primary or permanent	$32.00
D2160	Amalgam - three surfaces, primary or permanent	$37.00
D2161	Amalgam - four or more surfaces, primary or permanent	$50.00

D2330	Resin-based composite - one surface, anterior (*tooth colored*)	$55.00
D2331	Resin-based composite - two surfaces, anterior (*tooth colored*)	$65.00
D2332	Resin-based composite - three surfaces, anterior (*tooth colored*)	$75.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) (*tooth colored*)	$85.00
D2390	Resin-based composite crown, anterior	$85.00
D2391	Resin-based composite - one surface, posterior (*tooth colored*)	$75.00
D2392	Resin-based composite - two surfaces, posterior (*tooth colored*)	$80.00
D2393	Resin-based composite - three surfaces, posterior (*tooth colored*)	$85.00
D2394	Resin-based composite - four or more surfaces, posterior (*tooth colored*)	$95.00
D2510	Inlay - metallic - one surface [1, 4]	$260.00
D2520	Inlay - metallic - two surfaces [1, 4]	$270.00
D2530	Inlay - metallic - three or more surfaces [1, 4]	$280.00
D2542	Onlay - metallic - two surfaces [1, 4]	$270.00
D2543	Onlay - metallic - three surfaces [1, 4]	$290.00
D2544	Onlay - metallic - four or more surfaces [1, 4]	$300.00
D2610	Inlay - porcelain/ceramic - one surface [1, 6]	$360.00
D2620	Inlay - porcelain/ceramic - two surfaces [1, 6]	$370.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [1, 6]	$380.00
D2642	Onlay - porcelain/ceramic - two surfaces [1, 6]	$370.00
D2643	Onlay - porcelain/ceramic - three surfaces [1, 6]	$390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [1, 6]	$400.00
D2650	Inlay - resin-based composite - one surface (*tooth colored*) [1, 6]	$260.00
D2651	Inlay - resin-based composite - two surfaces (*tooth colored*) [1, 6]	$270.00
D2652	Inlay - resin-based composite - three or more surfaces (*tooth colored*) [1, 6]	$280.00
D2662	Onlay - resin-based composite - two surfaces (*tooth colored*) [1, 6]	$270.00
D2663	Onlay - resin-based composite - three surfaces (*tooth colored*) [1, 6]	$280.00
D2664	Onlay - resin-based composite - four or more surfaces (*tooth colored*) [1, 6]	$300.00
D2710	Crown - resin-based composite (indirect) [1, 6]	$125.00
D2712	Crown - 3/4 resin-based composite (indirect) [1, 6]	$125.00
D2720	Crown - resin with high noble metal [1, 6]	$425.00
D2721	Crown - resin with predominantly base metal [1, 6]	$325.00
D2722	Crown - resin with noble metal [1, 6]	$325.00
D2740	Crown - porcelain/ceramic [1, 6]	$425.00
D2750	Crown - porcelain fused to high noble metal [1, 6]	$425.00
D2751	Crown - porcelain fused to predominantly base metal [1, 6]	$325.00
D2752	Crown - porcelain fused to noble metal [1, 6]	$325.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$425.00
D2780	Crown - 3/4 cast high noble metal [1]	$425.00
D2781	Crown - 3/4 cast predominantly base metal [1]	$325.00
D2782	Crown - 3/4 cast noble metal [1]	$325.00
D2790	Crown - full cast high noble metal [1]	$425.00
D2791	Crown - full cast predominantly base metal [1]	$325.00
D2792	Crown - full cast noble metal [1]	$325.00

D2794	Crown - titanium and titanium alloys [1]	$425.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$20.00
D2920	Re-cement or re-bond crown	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior) (tooth colored)*	$85.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$80.00
D2931	Prefabricated stainless steel crown - permanent tooth	$80.00
D2940	Protective restoration	$20.00
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	$25.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [4]	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [4]	$50.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$70.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$45.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$65.00
D2980	Crown repair necessitated by restorative material failure	$50.00
D2981	Inlay repair necessitated by restorative material failure	$50.00
D2982	Onlay repair necessitated by restorative material failure	$50.00
D2983	Veneer repair necessitated by restorative material failure	$50.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$25.00
D3120	Pulp cap - indirect (excluding final restoration)	$25.00
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	$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$180.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$230.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$375.00
D3331	Treatment of root canal obstruction; non-surgical access	$180.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$180.00
D3346	Retreatment of previous root canal therapy - anterior	$280.00
D3347	Retreatment of previous root canal therapy - premolar	$330.00
D3348	Retreatment of previous root canal therapy - molar	$475.00
D3410	Apicoectomy - anterior	$270.00
D3421	Apicoectomy - premolar (first root)	$335.00
D3425	Apicoectomy - molar (first root)	$380.00
D3426	Apicoectomy (each additional root)	$105.00

D3430	Retrograde filling - per root	$50.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection*	$75.00
D3471	Surgical repair of root resorption - anterior	$270.00
D3472	Surgical repair of root resorption - premolar	$270.00
D3473	Surgical repair of root resorption - molar	$270.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$270.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$270.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$270.00

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$450.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$450.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	$20.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$60.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$45.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [2, 5]	$395.00
D5120	Complete denture - mandibular [2, 5]	$395.00
D5130	Immediate denture - maxillary [2, 5]	$495.00
D5140	Immediate denture - mandibular [2, 5]	$495.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [2, 5]	$300.00

D8000-D8999 XI. ORTHODONTICS - Not Covered

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure ..	$35.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$35.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9932	Cleaning and inspection of removable complete denture, maxillary ..	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular ...	No Cost
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$15.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$15.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

FOOTNOTES

1 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

2 *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.*

3 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

4 *Base or noble metal is the Benefit. If an inlay, onlay or 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 upgrade.*

5 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

6 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

7 *Limited to 1 per denture during any 12 consecutive months.*

SCHEDULE B

Limitations of Benefits

1. 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.

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. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.

5. Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.

6. The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling. Replacement of an existing crown, inlay or onlay that is non-functional or non-restorable is a benefit when the existing restoration is five+ years old.

7. A covered metallic inlay, onlay, and indirectly fabricated post and core 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.

8. 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 you elect 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.

9. If you also choose a porcelain margin for a covered porcelain-fused to metal crown, the maximum additional cost for this laboratory upgrade is $75.00.

10. Coverage for the placement of a fixed partial denture ("bridge") is limited to:

    a. The initial placement of a bridge when all the following conditions are present:
       - a single permanent tooth requires prosthetic replacement.
       - the abutment teeth can adequately support and retain a new bridge.
       - the missing tooth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture.
       - no other missing teeth in the same arch require prosthetic replacement with a new removable partial denture; and (*for a bridge replacing a posterior tooth*) one or more of the abutment teeth meet Limitation #6.

b. The replacement of an existing bridge that is not serviceable due to decay, fracture or other non-cosmetic defect, if:
   - the existing bridge is at least five years old; **and**
   - the same abutment teeth can adequately support and retain a new bridge; **and**
   - no other missing teeth in the same arch require prosthetic replacement.

11. Coverage for a new removable partial or complete denture is limited to:

    a. The initial placement of removable partial or complete denture in an arch when:
       - one or more permanent teeth require prosthetic replacement; **and**
       - the missing tooth/teeth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture; **and**
       - (for partial dentures only) there are suitable abutment teeth to retain and support a removable partial denture.

    b. The replacement of an existing removable partial or complete denture with non-cosmetic defect(s) that cause the denture to be non-serviceable if:
       - the existing removable denture is at least five years old; **and**
       - the existing removable denture cannot be made serviceable by adjustment, repair, relining or rebasing.

12. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.

13. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.

14. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.

15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.

16. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.

17. 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.

18. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, a large diastema between teeth or it interferes with a prosthetic appliance.

19. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.

20. 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 you continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

21. 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 you, and is subject to the limitations and exclusions of the Program. The applicable charge to you is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the covered procedure. Optional treatment does not apply when alternative choices are benefits.

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

Exclusions of Benefits

1. All procedures not shown in *Schedule A*, *Description of Benefits and Copayments*.

2. Dental conditions arising out of and due to your employment for which Workers' Compensation is paid. Services that are provided to you by state government or agency thereof, or are provided without cost 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 your eligibility with the DHMO Program. Examples include: teeth prepared for crowns, root canals in progress.

7. Congenital malformations.

8. Dispensing of drugs not normally supplied in a dental facility.

9. Any procedure that in the professional opinion of the Contract Dentist or our 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 preauthorized in writing by Delta Dental or as cited under Emergency Services. To obtain written authorization, you should call Delta Dental's Customer Service department at 800-422-4234.

11. Consultations for non-covered benefits.

12. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

14. 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).

15. 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 DHMO Program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not affect any other Benefits.

16. 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.

17. 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.

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

19. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue 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.

20. Treatment of retained primary teeth.

21. Specialist Services received from an orthodontist or pediatric dentist.

22. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

23. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.