

Platinum Plan

Delta Dental PPO

Services, Limitations and Exclusions

Description of Dental Services

We will pay the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, which is considered to be a Diagnostic and Preventive Benefit, and periodontal maintenance, which is considered to be a Major Benefit for payment purposes), topical application of fluoride solutions.
- (3) Specialist Consultations: opinion or advice requested by a general dentist.

- **Basic Services**

- (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- (2) Palliative: emergency treatment to relieve pain.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (5) Other Basic Services: space maintainers.

- **Major Services**

- (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
- (2) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (3) Periodontics: treatment of gums and bones supporting teeth.
- (4) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- (5) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges.
- (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.

- **Orthodontic Services**

Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- **Note on additional Benefits during pregnancy**

When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

- a) a composite restoration instead of an amalgam restoration on posterior teeth;
- b) a crown where a filling would restore the tooth;
- c) an inlay/onlay instead of an amalgam restoration;
- d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
- e) an overdenture instead of denture.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Exam and cleaning limitations:
 - a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
 - b) A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
 - c) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
 - d) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Major Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
 - e) Caries risk assessments are allowed once in 36 months.
- (3) X-ray limitations:
 - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 36 months.
 - e) Bitewing x-rays are limited to two (2) times in a Calendar Year for each Enrollee. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
 - f) Bitewing x-rays are limited to two images for Enrollees under age 10.
 - g) Image capture procedures are not separately allowable services.
- (4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.
- (5) Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.
- (6) Space maintainer limitations:

- a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
 - b) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- (7) Pulp vitality tests are allowed once in a six (6) month period when definitive treatment is not performed.
- (8) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.
- (9) Sealants are limited as follows:
 - a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
 - b) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- (10) Specialist Consultations are limited to two (2) in a Calendar Year and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered are limited to only one in a 12-month period and included if reported with any other examination on the same date of service and Provider office.
- (11) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
- (12) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (14) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (15) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, one (1) interim visit and one (1) final visit to age 19.
- (16) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (18) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service.
 - b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same Provider/Provider office.
 - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
 - d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
 - e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- (19) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

- (20) The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- (21) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- (22) Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).
- (23) Crowns are covered not more often than once in any 60-month period except when We determine the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (24) Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60-month period except when We determine the existing Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (25) Core buildup, including any pins, are covered not more than once in any 60-month period.
- (26) Post and core services are covered not more than once in any 60-month period.
- (27) Crown repairs are covered not more than once in any six (6) month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- (28) Denture Repairs are covered not more than once in any 24-month period except for fixed Denture Repairs which are covered not more than once in any 60-month period.
- (29) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if We determine it is unsatisfactory and cannot be made satisfactory.
- (30) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

- (31) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a six (6) month period by the same Provider/Provider office.
- (32) The initial installation of a prosthodontic appliance is not a Benefit unless the prosthodontic appliance, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.
- (33) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
 - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to one (1) per arch in a six (6) month period and relining is limited to one (1) per arch in a six (6) month period.

Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to one (1) per arch in a six (6) month period and relining is limited to one (1) per arch in a six (6) month period.
 - c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
 - d) Recementation of fixed partial dentures is limited to once in a six (6) month period.
- (34) We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but We will credit the cost of a pontic or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture. The implant appliance is not covered.
- (35) Limitations on Orthodontic Services:
 - a) The maximum amount payable for each Enrollee is shown in Attachment A.
 - b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
 - c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
 - d) Benefits are not paid for orthodontic retreatment procedures.
 - e) Benefits for Orthodontic Services are limited to dependent child Enrollees under the age of 26.
 - f) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
 - g) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
- (36) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

Exclusions

We do not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.

- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) fixed bridges and removable partials for Enrollees under age 16.
- (12) interim implants, endodontic endosseous implant and Extraoral implants.
- (13) indirectly fabricated resin-based Inlays/Onlays.
- (14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.
- (17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- (20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

- (22) the initial placement of any prosthodontic appliance, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- (23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- (24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) missed and/or cancelled appointments.
- (26) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (27) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (28) dental case management motivational interviewing and patient education to improve oral health literacy.
- (29) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (30) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (31) diabetes testing.
- (32) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (33) Antigen or antibody testing.
- (34) counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.