Attachment A
Deductibles, Maximums, Policy Benefit Levels and Enrollee Coinsurances

Deductibles & Maximums		
	Adult Benefits (age 19 and older)	**Pediatric Benefits (under age 19)**
Annual Deductible	The annual Deductible is waived for Diagnostic and Preventive Services.	
Enrollee	$50 each Calendar Year	$40 each Calendar Year
Family (three or more Enrollees)	$150 each Calendar Year	No family Deductible
Annual Maximum		
Enrollee	$1,000 each Calendar Year	No annual Maximum
Out-of-Pocket Maximum*		
Pediatric Enrollee	$375 each Calendar Year for only one covered Pediatric Enrollee	
Multiple Pediatric Enrollees	$750 each Calendar Year for two or more covered Pediatric Enrollees	

* Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by Delta Dental PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollee(s) equals the Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services received from Delta Dental PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Delta Dental Premier or Non-Delta Dental Providers even after the Out-of-Pocket Maximum is met.

If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from Delta Dental PPO Providers is not more than the multiple Pediatric Enrollees Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied their Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from Delta Dental PPO Providers until the total amount paid reaches the Out-of-Pocket Maximum for multiple Pediatric Enrollees.

Policy Benefit Levels & Enrollee Coinsurances				
	Adult Benefits (age 19 and older)		**Pediatric Benefits (under age 19)**	
Dental Service Category	**Delta Dental PPO[1]**		**Delta Dental PPO[1]**	
	Delta Dental[2]	Enrollee[2]	Delta Dental[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%
Medically Necessary Orthodontic Services (requires prior authorization)	Not a covered benefit	Not a covered benefit	50%	50%
Waiting Periods	Major Services are limited to Adult Enrollees who have been enrolled under this Policy for 12 consecutive months.[3]		No Waiting Periods	

[1] Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

[2] Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: Delta Dental will pay the same Policy Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

[3] Waiting Periods are calculated for each Adult Enrollee from the effective date of coverage reported by the Exchange for said Adult Enrollee. Prior coverage for Adult Enrollees under any Delta Dental Exchange plan that included an adult Waiting Period will be credited towards the adult Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (age 19 and older)

Delta Dental will pay or otherwise discharge the Policy 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: cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a Basic Service for payment purposes).
  - (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) Periodontal Cleanings: periodontal maintenance.
  - (3) Palliative: emergency treatment to relieve pain.
  - (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- Major Services
  - (1) 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.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
  - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
  - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (5) Periodontics: treatment of gums and bones supporting teeth.
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.

- Note on additional Benefits during pregnancy
  When an Enrollee is pregnant, Delta Dental 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 Policy 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 the Enrollee's Provider when the claim is submitted.

Limitations for Adult Benefits (age 19 and older)

(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; or
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).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental 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) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(3) Delta Dental will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a calendar year. See note on additional Benefits during pregnancy.

(4) Delta Dental will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year. 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 years, and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(5) A caries risk assessment is allowed once in 12 months.

(6) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(7) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

(8) X-ray limitations:

a) Delta Dental 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), Delta Dental 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, Delta Dental considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are not billable to the Enrollee or Delta Dental within 12 months of a full mouth series unless warranted by special circumstances.
f) Image capture procedures are not separately allowable services.

(9) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(10) Specialist Consultations are limited to once per lifetime per Provider 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) Delta Dental will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, 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 debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.

(15) 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.

(16) Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete endodontic therapy; inoperable, unrestorable or fractured tooth , are limited to once in a lifetime.

(17) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(18) Pin retention is covered not more than once in any 24-month period.

(19) 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.

(20) 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. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited 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 dentist/dental 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.
d) Guided tissue regeneration and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
f) 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.
g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

(21) Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

(22) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.

(23) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or 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.

(24) Core buildup, including any pins, is covered not more than once in any 60 month period.

(25) Post and core services are covered not more than once in any 60 month period.

(26) Crown and Inlay/Onlay repairs are covered not more than once in any 60 month period. Crowns, Inlays/Onlays and fixed bridges include repairs for twenty four (24) months following installation.

(27) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(28) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(29) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines 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. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant in 60 months, whether provided under Delta Dental or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a benefit allowance for the corresponding conventional removable appliances. The Enrollee is responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.

(30) Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in 36 months.

(31) Debridement of a peri-implant defect or defects surrounding a single implant (with or without osseous contouring), and surface cleaning of the exposed implant surfaces, including flap entry and closure, are covered once in 36 months.

(32) 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.

(33) Recementation of Crowns, Inlays/Onlays, indirectly fabricated or prefabricated post and core, 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 lifetime by the same Provider/Provider office.

(34) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.

(35) Occlusal adjustment - limited, is allowed once in a 60-month period.

(36) Delta Dental limits 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 two (2) per arch in a Calendar Year 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 two (2) per arch in a Calendar Year 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 lifetime.

(37) Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a

diastema.

(38) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

Exclusions for Adult Benefits (age 19 and older)

Delta Dental does 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.

(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 for cleft lip or cleft palate provided to newborn children at birth, children placed for adoption and adopted children so long as the children remain eligible.

(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.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) interim implants.

(12) indirectly fabricated resin-based Inlays/Onlays.

(13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(14) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(15) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(16) 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.

(17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(19) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(20) 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.

(21) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy 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.

(22) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(23) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(24) endodontic endosseous implants.

(25) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

(26) missed and/or cancelled appointments.

(27) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(28) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(29) dental case management motivational interviewing and patient education to improve oral health literacy.

(30) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(31) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(32) diabetes testing.

(33) corticotomy (specialized oral surgery procedure associated with orthodontics).

(34) antigen or antibody testing.

(35) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Description of Dental Services for Pediatric Benefits (under age 19)

Delta Dental will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for Essential Health Benefits when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- Diagnostic and Preventive Services

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
(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)	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)	Periodontal Cleanings:	periodontal maintenance.
(3)	Palliative:	emergency treatment to relieve pain.
(4)	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
(5)	Professional Visits:	visit to a Provider for observation or after regularly scheduled hours.

- Major Services

(1)	Crowns:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2)	Prosthodontics:	procedures for construction of partial or complete dentures.
(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	Denture Repairs:	repair to partial or complete dentures, including relining.
(7)	Night Guards/Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.
(8)	Temporary Tooth Stabilization:	temporary intraoral appliances and associated procedures provided for the stabilization of teeth having a mobility associated with advanced periodontal disease.

- Note on additional Benefits during pregnancy
  When an Enrollee is pregnant, Delta Dental 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 Policy 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 the Enrollee's Provider when the claim is submitted.

Limitations for Pediatric Benefits (under age 19)

(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.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental 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) Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Oral examination limitations:
- a) Periodic oral evaluations are limited to once every six (6) months. See note on additional Benefits during pregnancy.
- b) Limited oral evaluations are limited to three (3) times in a six (6) month period.
- c) Oral evaluation for a patient under three (3) years of age is covered for Enrollees age six (6) months up to age three (3).
- d) Comprehensive oral evaluations are limited to once every 12 months.
- e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

(6) X-ray limitations:
- a) Delta Dental 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), Delta Dental 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, Delta Dental considers the panoramic film to be included in the complete series.
- d) A complete intraoral series is limited to once every 11 months.
- e) A panoramic film is limited to once every 36 months.
- f) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are not billable to the Enrollee or Delta Dental within 12 months of a full mouth series unless warranted by special circumstances.
- g) Image capture procedures are not separately allowable services.

(7) Delta Dental will pay for routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than once every six (6) months**.** Topical application of fluoride varnish and topical application of fluoride are limited to no more than twice every six (6) months. Periodontal maintenance is limited to once every three (3) months. Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(8) Space maintainer limitations:
- a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance.
- b) A distal shoe space maintainer - fixed – unilateral is limited to children 8 and younger is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
- c) Limited to any combination of space maintainers not to exceed two (2) units within 12 months or four (4) units per lifetime.
- d) 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.

(9) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(10) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once in a 36-month period only in conjunction with medically necessary Orthodontic Services. If Orthodontic Services are covered, see Limitations as age limits may apply.

(11) Caries risk assessments are limited to no more than once in a 12-month period.

(12) Sealants are limited as follows:
- a) to permanent first and second molars limited to once per lifetime if they are without caries (decay) or restorations on the occlusal surface.
- b) do not include repair of a Sealant on any tooth within 24 months of its application.

(13) Specialist Consultations 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.

(14) Delta Dental will not cover to replace an amalgam, resin-based composite (fillings) within 36 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 36 months are included in the fee for the original restoration.

(15) Protective restorations (sedative fillings) are allowed twice per tooth in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

(16) Prefabricated stainless steel crowns on baby (deciduous) teeth and prefabricated resin crowns are limited to once every 36 months. Prefabricated stainless steel crowns on permanent teeth, usually up to age 16, are limited to once per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(17) Therapeutic pulpotomy is limited to once in a 36 month period for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

(18) Root canal therapy 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.

(19) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

(20) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(21) Pin retention is covered twice per tooth in any 36-month period. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(22) Palliative treatment is covered twice in a six (6) month period, and the fee for palliative treatment provided in conjunction with any procedures other than required x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

(23) Periodontal limitations:
- a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once every 12 months, not to exceed four (4) quadrants within a 12 month-period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.
- b) Periodontal surgery in the same quadrant is limited to once every 60 months, not to exceed four (4) quadrants within a 60-month period, and includes any surgical re-entry or scaling and root planing performed within 36 months by the same dentist/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.

d) Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
f) 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.

(24) Extractions and surgical extractions have a lifetime limit per tooth. Alveoloplasty in the same quadrant is limited to once per lifetime, not to exceed four (4) quadrants in a lifetime. Removal of cysts and lesions and incision and drainage procedures are covered once in the same day.

(25) Crowns are limited to Enrollees, usually age 12 and older. Services will only be allowed on teeth that are developmentally mature.

(26) Core buildup, including any pins, are covered not more than once in any 36 month period.

(27) Post and core services are covered once in a lifetime.

(28) When allowed within six (6) months of a restoration, the Benefit for a Crown or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(29) Labial veneer (porcelain laminate) – laboratory is limited to once in a lifetime.

(30) Denture Repairs are covered not more than once in any 60 month period. Partial repairs are not covered separate for 91 days following the original repair.

(31) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines 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. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.

(32) Recementation of Crowns or bridges is included in the fee for the Crown 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 of a Crown within a 12 month period by the same Provider/Provider office.

(33) 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.

(34) Delta Dental limits 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) 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 and relining are each 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 and relining are each limited to one (1) per arch in a six (6) month period.
b) 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 or reline service.

(35) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown, 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.

(36) Delta Dental will not cover the replacement of any appliances for Night Guard/Occlusal Guard or Temporary Tooth Stabilization Services.

(37) Frenulectomy and frenuplasty 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).

(38) Limitations on Orthodontic Services

a) Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a Benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
b) Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
c) The automatic qualifying conditions are:
    i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    ii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    iii. A crossbite of individual anterior teeth causing destruction of soft tissue,
    iv. Severe traumatic deviation.
d) The following documentation must be submitted with the request for prior authorization of services by the Provider:
    i. ADA 2006 or newer claim form with service code(s) requested;
    ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    iii. Cephalometric radiographic image or panoramic radiographic image;
    iv. HLD score sheet completed and signed by the Orthodontist; and
    v. Treatment plan.
e) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
f) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
g) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a Benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
j) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, Delta Dental will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
k) Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.
l) Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.
m) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

(39) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not separately payable service.

Exclusions for Pediatric Benefits (under age 19)

Delta Dental does not pay Benefits for:

(1) services that are not Essential Health Benefits.

(2) 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.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(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).

(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 for cleft lip or cleft palate provided to children at birth, children placed for adoption and adopted children so long as the children remain eligible.

(6) 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 or 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.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) laboratory processed crowns for Enrollees, usually under age 12.

(12) interim implants.

(13) indirectly fabricated resin-based Inlays/Onlays.

(14) overdentures.

(15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(18) 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.

(19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(21) Deductibles and/or any service not covered under the dental plan.

(22) 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.

(23) 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 Policy 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 must include the replacement of the extracted tooth or teeth.

(24) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.

(25) 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.

(26) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

(27) services or supplies for fixed prosthodontics (procedures for construction of fixed bridges), except to recement a fixed partial denture.

(28) services or supplies for denture rebase procedures.

(29) services or supplies for inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin- based composite.

(30) maxillofacial prosthetics.

(31) missed and/or cancelled appointments.

(32) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(33) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(34) dental case management motivational interviewing and patient education to improve oral health literacy.

(35) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(36) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(37) diabetes testing.

(38) corticotomy (specialized oral surgery procedure associated with orthodontics).

(39) antigen or antibody testing.

(40) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

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