

# Delta Dental PPO<sup>SM</sup>

## High Plan

### Diagnostic and Preventive Benefits and Limitations:

- Oral exams but not more than twice in a calendar year
- Full mouth or panoramic x-rays but not more than once every 36 months
- Bitewing x-rays but not more than twice per calendar year
- Cleaning of teeth (oral prophylaxis) but not more than twice in a calendar year
- Topical fluoride treatment twice in a calendar year for a dependent child 19 years of age or younger
- For dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 24 months
- For dependent children 19 years of age or younger, space maintainers

### Basic Benefits and Limitations:

- Intraoral-periapical x-rays and other x-rays not specified under Diagnostic and Preventive Benefits
- Pulp vitality tests
- Diagnostic casts
- Bacteriological studies for determinations of pathological agents
- Initial placement of amalgam or composite fillings
- Replacement of an existing amalgam or composite fillings
- Sedative fillings
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Periodontal maintenance where periodontal treatment (including scaling, root planing and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four (4) times per calendar year less the number of teeth cleanings received during such calendar year.
- Emergency palliative treatment to relieve tooth pain

### Major Benefits and Limitations:

- Prefabricated stainless steel crown or prefabricated resin crown, but not more than one per tooth within two (2) years
- Repair or re-cementing of Cast Restorations (Cast Restoration means an inlay, onlay or crown.)
- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period

- Periodontal scaling and root planing but not more than once per quadrant in any 24 month period
- Initial installation of Cast Restorations
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within five (5) years
- Oral surgery except as mentioned elsewhere
- Pulp therapy and apexification/recalcification
- Extractions of unimpacted teeth and removal of exposed roots
- Extractions of impacted teeth
- Root canal treatment but not more than once in a 24 month period for same tooth
- Initial installation of full or removable Dentures (Denture means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.)
- Addition of teeth to a partial removable Denture to replace natural teeth removed while covered dental services are in effect for the Enrollee receiving such services
- Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to replacement
- Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture
- Repair of Dentures
- Relinings and rebasings of existing removable Dentures if at least six (6) months have passed since the installation of the existing removable Denture and not more than once in any 36 month period
- Other removable prosthetic services not described elsewhere
- Other fixed Denture prosthetic services not described elsewhere
- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of five (5) years
- Adjustments of Dentures, if at least six (6) months have passed since the installation of the Denture
- Administration of general anesthesia and IV Sedation administered by a provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures
- Consultations, but not more than twice in a calendar year
- Injections of therapeutic drugs
- Local chemotherapeutic agents
- Fixed removable appliances for correction of harmful habits

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.



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### Orthodontic Benefits and Limitations:

- Orthodontic Services mean procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of misalignment of teeth and/or jaws which significantly interferes with their functions
- Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility
- Benefits are not paid to repair or replace any orthodontic appliance received under this program
- Benefits are not provided for orthodontic retreatment procedures

**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 this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

### Exclusions

- Treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law
- Cosmetic surgery or dentistry for purely cosmetic reasons
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), 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 dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity
- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment
- Any Single Procedure started prior to the date the Enrollee became covered for such services under this program
- Prescribed drugs, medication, pain killers or experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues)
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments
- Services or supplies covered by any other health plan of the Contract holder
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption
- Services for any disturbances of the temporomandibular (jaw) joints
- Replacement of a lost, missing or stolen crown, bridge or denture
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Temporary or provisional restoration
- Temporary or provisional appliance
- Adjustment of a denture or a bridgework which is made within six (6) months after installation by the same Dentist who installed it
- Any duplicate appliance or prosthetic device
- Charges made by a Dentist for failure to keep a scheduled visit with such Dentist
- Sterilization supplies
- Implantology
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards

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