

Limitations & Exclusions

Voluntary Groups of 5 - 100 Enrolled Employees

All Groups of 1 - 4 Enrolled Employees

DIAGNOSTIC & PREVENTIVE BENEFITS

Limitations on Diagnostic, Preventive and Adjunctive Benefits:

- a) Oral examinations are covered once in any 6-month period.
- b) Cleanings and/or any procedure that includes a component of cleaning, are covered once in any 6-month period. For individuals with certain medical conditions (as shown in the Employee Benefit Booklet), 2 additional cleanings (or any procedure that includes a component of cleaning) will be provided during a 12-month period.
- c) Topical fluoride application is covered through age 15 and only twice in 12 months.
- d) Full mouth x-rays are covered once every 60 months under any Delta Dental plan unless documentation of special need is provided. Individual bitewing x-rays are covered once every 12 months while the patient is under any Delta Dental plan. A panoramic survey (which may include bitewing x-rays and/or periapical x-rays) is considered a full mouth x-ray. Total allowance for individual periapical x-rays, intraoral occlusal x-rays, extraoral x-rays and/or bitewing x-rays performed on the same day will not exceed the allowance for full mouth x-rays.
- e) Space maintainers are covered for premature loss of primary back teeth through age 13.
- f) Sealants are covered once per tooth in any 36 consecutive month period for permanent first and second molars for children through age 14.

BASIC BENEFITS

Limitations on Basic Benefits:

- a) The same basic restorative service is covered once in any 24-month period for the same tooth.
- b) Composite fillings are covered on front teeth; amalgams on back teeth.
- c) Surgical periodontal services are covered once in any 36-month period for the same quadrant, tooth or site; non-surgical services are covered once in any 24-month period for the same quadrant.
- d) Pulpotomy/pulpectomy is covered only for primary teeth.
- e) A course of treatment for apexification/recalcification (initial, interim, and final visits) is covered once per tooth.

MAJOR BENEFITS

Limitations on Major Benefits - Special Restorative:

- a) Special restorative services (crowns, onlays and buildups) are covered once in any 84-month period per tooth.
- b) Any laboratory processed special restorative service or other special restorative service (except preformed shell crowns) is not covered for children under 16.
- c) Restorations on molar teeth will be limited to the allowance for a full metal restoration.

Limitations on Major Benefits - Prosthodontic

- a) Fixed prosthodontic services are covered once in any 84-month period per tooth; removable prosthodontic appliances are covered once in any 60-month period to replace the same missing teeth. Prosthodontic services are a benefit only to replace teeth extracted while covered.
- b) Fixed bridges (fixed partial dentures) and/or cast metal framework partial dentures (removable partial dentures) are not covered for persons under age 16.
- c) Fixed and removable prosthodontic appliances are not covered in the same arch. Allowance will be limited to the allowance for a removable appliance. Exception will be made when the fixed bridge (fixed partial denture) replaces front teeth.
- d) Reline or rebase of a prosthodontic appliance will be covered only once in any 36-month period.

ORTHODONTIC BENEFITS (ONLY if selected)

Limitations on Orthodontic Benefits:

- a) No benefits will be provided for:
 - Replacement or repair of appliances.
 - Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint.
- b) Periodic orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of eligibility.
- c) For an orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior payment history.

EXCLUSIONS

The following services are not benefits:

- a) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a covered service.
- b) Services for cosmetic reasons.
- c) Services for restoring tooth structure lost from wear, erosion, attrition, abrasion, or abfraction.
- d) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.
- e) Services related to periodontal stabilization of teeth.
- f) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) services, bite registration or analysis, or any related services.
- g) Pre-medication, analgesia, hypnosis or any other patient management services (except covered anesthetic services).
- h) Charges for prescription drugs.
- i) Any experimental or investigational procedures.
- j) Hospital costs and any additional fees charged by the dentist or hospital for hospital services or visits, or charges for use of any facility.
- k) Any anesthesia service not specifically included in covered services.
- l) Intraoral grafts when done in areas where a tooth/teeth are not present.
- m) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any associated services.
- n) Myofunctional therapy or speech therapy.
- o) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions.
- p) Oral hygiene instructions or dietary instructions. Preventive control programs, including home care items.
- q) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records. Missed appointment charges.
- r) Replacement of lost, stolen or damaged appliances.
- s) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
- t) Implant placement and implant restorative procedures.

This form provides a brief description of limitations and exclusions. The Employee Benefit Booklet provides a more complete explanation of coverage, including limitations and exclusions.