

DELTA DENTAL PPOSM FAMILY DENTAL PPO FOR SMALL BUSINESSES

A HEALTHY MOUTH STARTS HERE. GET COVERED. SAVE MONEY. SMILE BRIGHT.

SMILE HEALTHY

Get the coverage enrollees need and access to the largest number of network dentists nationally with Delta Dental PPO.^{1,2} Our easy-to-use plan helps keep smiles healthy. Learn more and purchase today!

GO PPO!

A Delta Dental PPO plan gives enrollees access to a network of dentists who've agreed to keep costs low. There are no service area restrictions so they're covered anywhere they go. And since four out of five dentists nationally are participating dentists, enrollees may already be visiting a network dentist.

Delta Dental PPO covers checkups, cleanings and x-rays to help keep smiles bright. It covers lots of other great services, too. After enrollees satisfy the plan's deductible, they'll be responsible for a coinsurance percentage, which is their share of the charges – Delta Dental pays the rest.³



WHY CHOOSE THIS PLAN?

- › Checkups, cleanings and x-rays covered
- › Large network for maximum savings
- › Visit any licensed dentist
- › No ID card needed
- › Easy claims
- › Find plan information, claims, dentists and ID cards using a smartphone or PC

deltadentalins.com

Delta Dental of California
100 First Street
San Francisco, CA 94105

Customer Service
800-471-0287

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330





DENTAL IS IMPORTANT...

Give employees peace of mind with a Delta Dental PPO plan. The right coverage can help them protect their smiles and their wallets.

MORE WAYS TO SAVE

Visit a Delta Dental PPO dentist.

Enrollees usually pay less when they visit a PPO network dentist. Enrollees can go to the Find a Dentist tool on our home page to search for a PPO dentist. (We offer results by mobile device location too!) Our large network makes it easy to find a convenient participating dentist.

For additional choice, our Delta Dental Premier® dentists offer enrollees another way to save. These dentists are not “in-network,” but enrollees will usually pay less than if they visit a non-Delta Dental dentist.

EASY TO USE

No ID card needed.

Enrollees can simply provide the dental office their name, date of birth and social security or enrollee identification number. No ID card is required. Or they can log in on their smartphone or mobile device and display their mobile ID card.

Claims are a breeze.

Enrollees pay only their portion of the bill for services when they visit a Delta Dental dentist; we take care of the rest. After a claim is processed, we provide enrollees a statement that explains the services provided and their share of the cost. Increase the convenience by signing up for paperless statements.

Quick and easy online information

Enrollees can manage their accounts online wherever they are — work, home or on the go. Our tools help enrollees access plan information, view claims, find dentists and display ID cards.

SUPPORT HEALTHY HABITS

Access to the SmileWay® Wellness Program

Check out our great oral health resources! They can help your employees stay informed and stay healthy. SmileWay offers risk assessment quizzes, articles, videos, fun stuff for kids and a subscription to Grin!, our free dental wellness e-magazine.

Coverage for peace of mind

Skipping preventive care can lead to more expensive treatment that could easily cost more than a full year’s premium (and could contribute to lost time at work). A Delta Dental PPO plan can help your employees and their families stay healthy and avoid more costly care. Plus, our plans provide additional peace of mind with no service area restrictions.

¹ In Texas, Delta Dental Insurance Company underwrites a Dental Provider Organization (DPO) plan.

² NetMinder Dental Network Trend Report, March 2015.

³ Enrollees are responsible for amounts for any applicable deductibles and for non-covered services. For adult benefits, once the plan maximum is reached, all charges are the responsibility of the patient.

This benefit information is only a summary and not intended or designed to replace or serve as the plan’s Group Contract. Please consult the Evidence of Coverage for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the Evidence of Coverage, the terms of the Evidence of Coverage will prevail. To view a copy of the Evidence of Coverage, [click here](#) or call 800-471-0287.

Delta Dental PPOSM

Family Dental PPO for Small Businesses

Plan Highlights	Pediatric Benefits (up to age 19)		Adult Benefits (age 19 and older)		
Deductibles & Maximums per Contract Year					
Deductible	Per enrollee	\$65	\$50		
	Family	\$130	Not Applicable		
Deductible Waived for Diagnostic and Preventive Services		Yes	Yes		
Annual Maximum Maximum the plan will pay each year for services per person.		None	\$1,500		
Out-of-Pocket Maximum After this amount is reached, the plan pays 100% of the remaining covered services for that year. Applies only to in-network services.		\$350 for one pediatric enrollee, \$700 for two or more pediatric enrollees		None	
Covered Services^{1,2}		<i>Delta Dental pays</i>	<i>Enrollee pays</i>	<i>Delta Dental pays</i>	<i>Enrollee pays</i>
Diagnostic and Preventive Services		100%	0%	100%	0%
Basic Services		80%	20%	80%	20%
Major Services		50%	50%	50%	50%
Orthodontic Services Medically necessary (requires prior authorization)		50%	50%	Not a benefit	Not a benefit
Waiting Period(s) Major Services		None		6 months	

¹ Reimbursement to dentists is based on contracted fees. Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Please refer to your plan Policy or Evidence of Coverage for complete limitations and exclusions for this plan.

² Coverage may not be available in all areas. Service area coverage and/or restrictions are listed in the limitations and exclusions.

Services, Limitations and Exclusions

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

Delta Dental will pay or otherwise discharge 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 (periodontal cleaning in the presence of inflamed gums 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 stainless steel 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 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 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) Delta Dental will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a Calendar Year.
- (3) Delta Dental will pay for cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- (4) 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 disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- (5) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (6) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.
- (7) Delta Dental will not cover to replace an amalgam, resin-based composite or prefabricated resin and stainless steel 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.
- (8) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (9) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (10) Root canal therapy and pulpal therapy (resorbable filling) are 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.
- (11) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (12) Pin retention is covered not more than once in any 24-month period.
- (13) 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.
- (14) 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.
 - 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.
 - 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) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
 - 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.
- (15) 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.
- (16) 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.

- (17) When an alternate Benefit of an amalgam is allowed for inlays/onlays, they are covered not more than once in any 60 month period.
- (18) Core buildup, including any pins, are covered not more than once in any 60 month period.
- (19) Post and core services are covered not more than once in any 60 month period.
- (20) Crown repairs are covered not more than once in any 60 month period.
- (21) 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.
- (22) 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.
- (23) 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 during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- (24) 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.
- (25) 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 lifetime by the same Provider/Provider office.
- (26) 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.
- (27) 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.
 - 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.

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

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

Delta Dental will pay or otherwise discharge the Contract 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 a 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) Initial and periodic oral examinations;
- (2) Consultations, including specialist consultations;
- (3) Topical fluoride treatment;
- (4) Preventive dental education and oral hygiene instruction;
- (5) Roentgenology (x-rays);
- (6) Prophylaxis services (cleanings);
- (7) Dental sealant treatments; and
- (8) Space Maintainers, including removable acrylic and fixed band type.

- **Basic Services**

- (1) Restorations which includes the following:
 - a) Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries;
 - b) Micro filled resin restorations which are non-cosmetic;
 - c) Replacement of a restoration;
 - d) Use of pins and pin build-up in conjunction with a restoration; and
 - e) Sedative base and sedative fillings;
 - f) Prefabricated acrylic and stainless steel crowns.
- (2) Other dental benefits which includes the following:
 - a) Local anesthetics;
 - b) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure;
 - c) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure; and
 - d) Emergency treatment, palliative treatment.

- **Major Services**

- (1) Oral Surgery which includes the following:
 - a) Extractions, including surgical extractions;
 - b) Removal of impacted teeth;
 - c) Biopsy of oral tissues;
 - d) Alveolectomies;
 - e) Excision of cysts and neoplasms;
 - f) Treatment of palatal torus;
 - g) Treatment of mandibular torus;
 - h) Frenectomy;
 - i) Incision and drainage of abscesses;
 - j) Post-operative services, including exams, suture removal and treatment of complications; and
 - k) Root recovery (separate procedure).
- (2) Endodontic which includes the following:
 - a) Direct pulp capping;
 - b) Pulpotomy and vital pulpotomy;
 - c) Apexification filling with calcium hydroxide;
 - d) Root amputation;
 - e) Root canal therapy, including culture canal and limited retreatment of previous root canal therapy;
 - f) Apicoectomy; and
 - g) Vitality tests.
- (3) Periodontics which includes the following:
 - a) Emergency treatment, including treatment for periodontal abscess and acute periodontitis;
 - b) Periodontal scaling and root planing, and subgingival curettage;
 - c) Gingivectomy; and

- d) Osseous or muco-gingival surgery.
- (4) Crowns and Fixed Bridges which includes the following:
- a) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown;
 - b) Related dowel pins and pin build-up;
 - c) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold;
 - d) Recementation of crowns, bridges, inlays and onlays;
 - e) Cast post and core, including cast retention under crowns; and
 - f) Repair or replacement of crowns, abutments or pontics.
- (5) Removable Prosthetics which includes the following:
- a) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers;
 - b) Office or laboratory relines or rebases;
 - c) Denture repair;
 - d) Denture adjustment;
 - e) Tissue conditioning;
 - f) Denture duplication; and
 - g) Stayplates.

Limitations for Pediatric Benefits (under age 19)

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II Services

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.

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.

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 Contract. 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.

- **Diagnostic and Preventive Services**

- (1) Roentgenology (x-rays) is limited as follows:
 - a) Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
 - b) Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months.
 - c) Panoramic film x-rays are limited to once every twenty-four (24) consecutive months.
 - d) Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.
 - e) Dental sealant treatments are limited to only permanent first and second molars.

- **Basic Services**

- (1) Restorations are limited as follows:
 - a) Treatment of caries for a tooth that can be restored with amalgam, composite resin, acrylic, synthetic, plastic restorations or prefabricated acrylic or stainless steel crowns. Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown. Any other restoration such as a crown or jacket is considered an Optional Service.

- b) Composite resin or acrylic restorations in posterior teeth are Optional Services.
- c) Replacement of a restoration is covered only when it is defective (as evidenced by conditions such as recurrent caries or fracture) and replacement is dentally necessary.

- **Major Services**

- (1) Oral Surgery benefit is limited as follows:
 - a) The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
- (2) Endodontics - Root canal therapy, including culture canal, is limited as follows:
 - a) Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
 - b) Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- (3) Periodontics benefit is limited as follows:
 - a) Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.
- (4) Crown benefit is limited as follows:
 - a) Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the dental plan.
 - b) Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
 - c) Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- (5) The Fixed Bridge benefit is limited as follows:
 - a) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Service.
 - b) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered an Optional Service. If performed on a Enrollee under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
 - c) Fixed bridges used to replace missing posterior teeth are considered an Optional Service when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
 - d) Fixed bridges are an Optional Service when provided in connection with a partial denture on the same arch.
 - e) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
 - f) The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction. Full mouth reconstruction is considered an Optional Service.
- (6) Removable Prosthetic benefit is limited as follows:
 - a) Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
 - i. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
 - ii. The denture is unsatisfactory and cannot be made satisfactory.
 - b) The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. More elaborate or precision appliances, if chosen by the patient and the Provider, and are not necessary to satisfactorily restore an arch are considered Optional Services. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered Optional Services.
 - c) Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
 - d) The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. More personalized or specialized treatment chosen by the patient and the Provider are considered Optional Services.
 - e) Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.
 - f) Tissue conditioning is limited to two (2) per denture.
 - g) Implants are considered an Optional Service.
 - h) Stayplates are a benefit only when used as anterior space maintainers for children.

- **Medically Necessary Orthodontic Services**

- (1) Limitations on Orthodontic Services
 - a) Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. 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.

Exclusions for Pediatric Benefits (under age 19)

Delta Dental does not pay Benefits for:

- (1) services that are not Essential Health Benefits.
- (2) any service that is not specifically listed as a covered benefit.
- (3) services not necessary to the Enrollee's dental health as determined by the attending Provider.
- (4) procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Description of Dental Services section.
- (5) 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.
- (6) cosmetic surgery or procedures for purely cosmetic reasons.
- (7) maxillofacial prosthetics.

- (8) 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 children for medically diagnosed congenital defects or birth abnormalities.
- (9) 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, or complete occlusal adjustments.
- (10) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (11) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (12) 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.
- (13) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (14) laboratory processed crowns for Enrollees under age 12.
- (15) fixed bridges and removable partials for Enrollees under age 16.
- (16) interim implants.
- (17) indirectly fabricated resin-based Inlays/Onlays.
- (18) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (19) major surgery for fractures and dislocations.
- (20) loss or theft of dentures or bridgework.
- (21) malignancies.
- (22) additional treatment costs incurred because a dental procedure is unable to be performed in the Provider's office due to the general health and physical limitations of the Enrollee.
- (23) the cost of precious metals used in any form of covered Benefits.
- (24) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (25) 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.
- (26) 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.
- (27) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (28) 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.
- (29) Deductibles and/or any service not covered under the dental plan.
- (30) 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.
- (31) 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 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.
- (32) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(33)endodontic endosseous implant.

(34)the surgical removal of implants.

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

Service Areas

Coverage is available in the following counties in California:

Full Counties (plan available anywhere in the county):

Alameda
Alpine
Amador
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Kings
Lake
Los Angeles
Madera
Marin
Mariposa
Merced
Monterey
Napa
Nevada
Orange
Placer
Plumas
Sacramento

San Benito
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Solano
Stanislaus
Sutter
Trinity
Tulare
Ventura
Yolo
Yuba

Partial counties (plan available only in certain areas of the county):

Imperial
Inyo
Kern
Lassen
Modoc
Mono
Riverside
San Bernardino
Siskiyou
Tehama
Tuolumne