

## Delta Dental Premier®, PPO Limitations and Exclusions

**Contributory and Voluntary:** The following is a brief summary of the benefit limitations and exclusions for the dental plan(s) quoted. Please refer to your dental contract for a complete list.

### Limitations on Type I

- Oral examinations and cleanings - once in any 6-month period
- Topical fluoride - once in 12 months under age 16.
- Bitewing x-rays – once per 12 months.
- Full mouth x-rays - once per 60 months.
- Sealants - once per tooth in any 36 consecutive month period under age 15.

### Limitations on Type II

- Amalgam fillings - once per 24-month period.

### Limitations on Type IIIA

- Surgical Periodontic Services - once in any 36 month period. Non-Surgical Periodontic Services - once in any 24 month period.
- Periodontal cleanings are included in the cleaning limitations shown above.
- Reline or Rebase of a prosthodontic appliance will be once in any 36 month period.

### Limitations on Type IIIB

- Benefit for placement of Crowns and Onlays will not be provided more than once in any 84-month period involving restorations of the same tooth.
- Allowance for Crowns, Inlays, and Onlays posterior to the first molar will be limited to the allowance for a full metal restoration. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.
- Initial placement of full or partial Dentures is only a benefit to replace a natural tooth that was extracted while the patient was covered under this contract. Benefit for replacement is once per 60-month period if it cannot be repaired or made serviceable.
- Initial placement of fixed bridges is only a benefit to replace a natural tooth that was extracted while the patient was covered under this contract. Benefit for replacement is once per 84-month period if it is not serviceable, and cannot be repaired.

### Limitations on Orthodontic Benefits (if covered)

- Replacement or repair of appliances is not covered.
- Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions is not covered.
- Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility.
- 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 benefit.

## EXCLUSIONS

### The following Services are not Benefits:

- Any Covered Service Started when the person was not eligible for such Service under this Contract.
- 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.
- Services for cosmetic reasons.
- Services for restoring tooth structure lost from wear, erosion, attrition, abrasion or abfraction.
- Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.
- Services related to periodontal stabilization of teeth. Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services
- Charges for prescription drugs.
- Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility. Any anesthesia service not specifically included in Covered Services.
- Orthodontic Services unless shown as covered on the Summary of Dental Plan Benefits.
- Myofunctional therapy or speech therapy.
- Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain or any related conditions.
- Oral hygiene instructions or dietary instructions.
- Replacement of lost, stolen or damaged appliances.
- Repair of appliances altered by someone other than a Dentist.
- Any Services including any associated Services or procedures not specifically included in Covered Services.
- Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.