Plan Provisions – Exchange Certified Products
(The following limitations and exclusions apply to enrollees age 19 and over if adult coverage is included in the rate quote).

Delta Dental Limitations
The following benefits have limitations as indicated.

Diagnostic and Preventive Care (Type I) – No Deductible
• Oral exams and cleanings are covered twice each 12-consecutive month period.
• Bitewing radiographic images (X-rays) are covered once each 12-consecutive month period, limited to four films in one visit.
• Full mouth (panorulpe) X-rays: limit of one every three years for Employer-Paid plans, one every five years for voluntary (Employee-Paid) plans. Full mouth X-ray includes bitewing X-rays. Panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
• Full mouth debridement is limited to once in a lifetime and is only a covered benefit when an enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.

Basic Dental Care (Type II) – Deductible Applies
• Amalgam and composite fillings: except as otherwise provided in the plan documents, composite (white) fillings limited to upper six and lower six anterior (front) teeth; once in a 24-month period per tooth, per surface.
• Denture repair and recementation of crowns, bridges and dentures: limited to once in a 12-month period after six months from initial placement.
• Endodontic services/root canal therapy: retreatment only after 24 months from initial root canal therapy treatment and is limited to once in a lifetime.
• Periodontal services: Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings. Limitations of 24 to 36 months apply based on services rendered.

Major Dental Care (Type III), If Applicable – Deductible Applies
• Crowns: once per tooth every 60 months, and only when an existing crown cannot be rendered serviceable. Benefit is available only when the tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or composite restoration.
• Prosthodontics/dentures/bridges not related to an implant: once every 60 months, and only when an existing prosthesis cannot be rendered serviceable. Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.

Orthodontic Benefits (Type IV), If Applicable – No Deductible
• Minimum of 10 enrolled (minimum of two for aXcess).
• Orthodontic benefits are available to all enrollees on Employer-Paid plans. Voluntary (Employee-Paid) plans cover dependent children up to age 19 only.

MaxOver® Benefit
Eligibility for MaxOver benefits are determined three months after the end of the plan benefit period. Any claims processed or adjusted after a member’s annual MaxOver eligibility is determined will not alter the individual’s eligibility for the benefit. Orthodontic benefits (if covered) are excluded from the MaxOver program. MaxOver benefits cease to be available when a member’s coverage under the group contract terminates.

Delta Dental Exclusions
The following are not covered benefits unless specifically identified as a covered benefit in Delta Dental’s plan documents:
• Services or supplies that are not dental services; also services not specifically listed as covered in the group’s Schedule of Benefits.
• Services or treatment provided by someone other than a licensed dentist or a qualified licensed dental hygienist working under the supervision of a dentist.
• A dental service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally-accepted dental practice standards based on the dental services provided. In addition, each covered benefit must demonstrate dental necessity. Dental necessity is determined in accordance with generally accepted standards of dentistry.
• Dental services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also, benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.

Continued on next page.
Plan Provisions – Exchange Certified Products
(The following limitations and exclusions apply to enrollees age 19 and over if adult coverage is included in the rate quote).

Delta Dental Exclusions
• Dental services started or rendered before the date enrolled under the group contract. Also, except as otherwise noted, benefits for a course of treatment that began before you are enrolled under the group contract.
• Except as otherwise provided for in the plan documents, dental services provided after the date you are no longer enrolled or eligible for coverage.
• Except as otherwise provided for in the plan documents, prescription and non-prescription drugs, pre-medications, preventive control programs, oral hygiene instructions and relative analgesia.
• General anesthesia when less than three teeth will be routinely extracted during the same office visit.
• Splinting or devices used to support, protect or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
• Charges for inpatient or outpatient hospital services and any additional fee that the dentist may charge for treating a patient in a hospital, nursing home or similar facility.
• Charges to complete a claim form, copy records or respond to Delta Dental’s requests for information.
• Charges for failure to keep a scheduled appointment.
• Charges for consultations in person, by phone or by other electronic means.
• Charges for X-ray interpretation.

• Dental services to the extent that benefits are available or would have been available if you had enrolled, applied for or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
• Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under this plan or any similar coverage.
• Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist’s parent, spouse or child.
• Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
• Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
• Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis, including but not limited to, hereditary ectodermal dysplasia or not related to a medical diagnosis.
• Experimental or investigative dental procedures, services, and supplies, as well as services and/or procedures due to complications thereof, which, in the judgment of Delta Dental: (a) are in a trial stage, (b) are not in accordance with generally accepted standards of dental practice or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee’s condition.
• Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
• Dental services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
• Services billed under multiple dental service procedure codes, which Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental bases their payment on the negotiated fee for the more comprehensive code, not on the negotiated fee for the underlying component codes.
• Services billed under a dental service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases their payment on its determination of the more accurate dental service code.
• Amounts assessed on dental services and/or supplies by state or local regulation.
• Amounts that exceed the negotiated fee as agreed to by the dentist for covered benefits.
Plan Provisions – Exchange-Certified Products

(These limitations and exclusions apply to enrollees under the age of 19.)

Delta Dental Limitations

The following benefits have limitations as indicated.

Diagnostic and Preventive Care (Type I), Preferred Plan – No Deductible, Basic Plan – Deductible Applies

• Oral exams (includes periodic exams for patients under three years of age, comprehensive, detailed and extensive evaluation and exam): twice in a 12-month period.
• Emergency exams (limited-problem focused): twice in a 12-month period.
• Bitewing X-rays (including vertical bitewings): one set in a 12-month period.
• Intraoral-periapical X-rays: six films in a six-month period.
• Intraoral-occlusal X-rays: twice in a 12-month period.

Basic Dental Care (Type II) – Deductible Applies

• Amalgam (silver) and composite (white) fillings: once in a 12-month period per tooth, per surface.
• Prefabricated stainless steel crowns (primary teeth): allowed on primary (baby) teeth, once in a 24-month period.
• Protective restoration (sedative filling): not allowed when performed in conjunction with root canal therapy, pulpotomy or on the same date of service as a restoration.
• Pin retention: once per tooth for permanent teeth when completed on same day as restoration.
• Therapeutic pulpotomy: excluding final restoration: once per tooth for primary teeth.
• Pulpal debridement: once per tooth.
• Root canal therapy (anterior, bicuspids or molar), excluding final restoration: retreatment allowed after two years from initial root canal therapy; once in a lifetime.
• Gingivectomy or gingivoloplasty: once per quadrant in a 24-month period.
• Gingival flap procedure, including general anesthesia: once per quadrant in a 36-month period.
• Osseous surgery, including general anesthesia: once per quadrant in a 36-month period.
• Autogenous and non-autogenous connective tissue graft procedures: distal or proximal wedge procedure; combined connective tissue and double pedicle graft: once per site in a 36-month period.
• Periodontal scaling and root planing: once per quadrant in a 24-month period.
• Incisional biopsy of oral tissue (hard and soft), including general anesthesia: twice in a 24-month period.
• Brush biopsy – transepithelial sample collection: twice in a 24-month period.
• Alveolectomy, including general anesthesia: once per quadrant.
• Removal of lateral exostosis, torus palatinus, torus mandibularis, including general anesthesia: once in a 60-month period.
• Maxillary sinusotomy for removal of tooth fragment or foreign body, including general anesthesia: once in a 12-month period.
• Frenulectomy and frenuloplasty, including general anesthesia: once in a lifetime.
• Excision of hyperplastic tissue, including general anesthesia: once in a 60-month period.
• Excision of pericoronal gingiva, including general anesthesia: once in a 36-month period.

Major Dental Care (Type III) – Deductible Applies

• Onlays and single crowns: once every 60 months when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
• Temporary crowns limited to a fractured tooth. Not to be used as a temporary crown during crown fabrication.
• Labial veneers: once every 60 months when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration, limited to the upper and lower front teeth.
• Cast and prefabricated post and core in addition to crown, core buildup, and crown repair: once every 60 months.
• Re-cement or re-bond fixed inlays, onlays, veneers or partial coverage restorations; re-cement or re-bond indirectly-fabricated or prefabricated post and cores; re-cement or re-bond crowns; re-cement or re-bond implant/abutment supported fixed partial denture: once in a 12-month period after six months from initial placement of partial denture.
• Repairs to complete and partial dentures: once in a 12-month period after six months from initial placement of complete or partial denture.

Orthodontic Benefits (Type IV), if applicable – No Deductible

• Minimum of 10 enrolled (minimum of two for Acess).
• Orthodontic benefits are available to all enrollees on Employer-Paid plans. Voluntary (Employer-Paid) plans cover dependent children up to age 10 only.

Medically-Necessary Orthodontic Benefits

• Treatment necessary for the proper alignment of teeth. Members must have a severe, dysfunctional, handicapping malocclusion. In order to qualify as medically necessary, a minimum score of 25 points using Salzmann Index criteria is required. Handicapping esthetic diagnoses (crooked, crowded or protruding teeth) due to appearance are not considered part of the determination.

Continued on next page.
Plan Provisions - Exchange-Certified Products
(The following limitations and exclusions apply to enrollees under the age of 19.)

Delta Dental Exclusions
The following are not Covered Benefits unless specifically identified as a Covered Benefit in the Schedule of Benefits:

- Services or supplies that are not Dental Services; also services not specifically listed as covered in the Schedule of Benefits.
- Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist.
- A Dental Service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Dental Necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry.
- Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental Services for the diagnosis or treatment for illnesses, injuries or other conditions you are eligible for coverage under your hospital, medical/surgical or major medical plan.
- Dental Services provided before the date you enrolled under the plan.
- Dental Services provided after the date you are no longer enrolled or eligible for coverage.
- Except as otherwise provided for in the plan documents, prescription and non-prescription drugs, pre-medications, preventive control programs, oral hygiene instructions and relative analgesia.
- General anesthesia when less than three teeth will be routinely extracted during the same office visit.
- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records or respond to Delta Dental’s requests for information.
- Charges for failure to keep a scheduled appointment.
- Charges for consultations by phone or by other electronic means.
- Charges for radiographic image (X-ray) interpretation.
- Dental Services to the extent that benefits are available or would have been available if you had enrolled, applied for or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or Dental Services for which you would not be obligated to pay in the absence of the coverage under this plan or any similar coverage.
- Services or treatment provided to an immediate family member by the treating Dentist. This would include a Dentist’s parent, spouse or child.
- Dental Services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis, including but not limited to, hereditary ectodermal dysplasia or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services or supplies, as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice; or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee’s condition.
- Services billed under multiple Dental Service procedure codes which Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive Dental Service procedure code. Delta Dental bases its payment on the Plan Allowance for the more comprehensive code, not on the Plan Allowance for the underlying component codes.
- Services billed under a Dental Service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the Dental Service. Delta Dental bases its payment on its determination of the more accurate Dental Service code.
- Amounts assessed on Dental Services and/or supplies by state or local regulation.
- Charges for routine recalls and restorative procedures unless specifically covered.
- Charges for failure to keep scheduled appointments.
- Charges to complete a claim form, copy records or respond to Delta Dental’s requests for information.
- Charges for treatment or services that are non-medically necessary, non-essential or of an experimental nature.
- Charges to complete a claim form, copy records or respond to Delta Dental’s requests for information.
- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records or respond to Delta Dental’s requests for information.
- Charges for failure to keep a scheduled appointment.
- Charges for consultations by phone or by other electronic means.
- Charges for radiographic image (X-ray) interpretation.
- Dental Services to the extent that benefits are available or would have been available if you had enrolled, applied for or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or Dental Services for which you would not be obligated to pay in the absence of the coverage under this plan or any similar coverage.
- Services or treatment provided to an immediate family member by the treating Dentist. This would include a Dentist’s parent, spouse or child.
- Dental Services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis, including but not limited to, hereditary ectodermal dysplasia or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services or supplies, as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice; or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee’s condition.
- Services billed under multiple Dental Service procedure codes which Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive Dental Service procedure code. Delta Dental bases its payment on the Plan Allowance for the more comprehensive code, not on the Plan Allowance for the underlying component codes.
- Services billed under a Dental Service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the Dental Service. Delta Dental bases its payment on its determination of the more accurate Dental Service code.
- Amounts assessed on Dental Services and/or supplies by state or local regulation.

• Amounts that exceed the Plan Allowance as agreed to by the dentist for covered benefits.
• Non-medically necessary orthodontic treatment, unless included as a covered benefit on the Traditional plan that has been amended to include the Pediatric Exchange-Certified Amendment.