

Dental Care

Preventive and diagnostic dental services are covered for adults age 19 and over. Covered services include an oral examination and cleaning twice per calendar year. For individuals with a history of prior definitive periodontal treatment, or the following medical conditions, two additional cleanings will be provided during the calendar year.

- » Diabetes with documented gum conditions,
- » Pregnancy with documented gum conditions,
- » Cardiovascular disease with documented gum conditions,
- » Kidney failure with dialysis, and
- » Suppressed immune system due to chemotherapy or radiation treatment, HIV positive status, organ transplant or stem cell (bone marrow) transplant.

Bitewing x-rays and full-mouth x-rays are covered once per calendar year unless documentation of special need is provided. Services must be provided by Delta Dental PPO providers in order to be covered.

ADULTS 19 AND OVER:

In-network: 100% covered.

Out-of-network: Not covered.

PEDIATRIC DENTAL BENEFIT:

In-network: Not covered.

Out-of-network: Not covered.

Limitations/Exclusions (what is not covered)

GENERAL LIMITATIONS – ALL SERVICES

- » Alternate benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, plan will consider other materials and methods of treatment. Payment will be limited to the covered amount for the least costly covered service that meets accepted standards of dental care as determined by Delta Dental. The covered person and their provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure using the coinsurance level shown on the Explanation of Coverage (EOC). Payment will be limited to the covered amount for the least costly treatment. Only covered services are eligible to receive alternate benefits.
- » Plan will pay for procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.
- » Services are covered when provided by a person legally permitted to perform such services and are determined to be necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's processing policies, even if no monies are paid.
- » The covered amount for a covered service started but not completed will be limited to the amount determined by Delta Dental.
- » Services related to another category of covered services may be covered at the same percentage as the related category of covered services.
- » Covered services will not be compensated when delivered in response to injuries or conditions

which are covered under worker's compensation or employer's liability laws.

- » Covered services will not be compensated when provided by any federal or state agency.
- » Covered services provided without cost by any city, county or other political subdivision will not be compensated.
- » Covered services for which the person would not have to pay if not insured—such as those delivered to a family member or employee of the provider—will not be compensated.
- » Any covered service started when the person was not covered under this contract will not be compensated. This includes any service started during an applicable waiting period.
- » Covered services not performed in accordance with Colorado state law will not be compensated.
- » Covered services will not be compensated if administered by any person other than a person licensed to perform them.
- » Covered services to treat any condition, other than an oral or dental disease, abnormality or condition will not be compensated.
- » Covered services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid, will not be compensated.
- » Covered services will not be compensated when delivered as a result of self-injury.

EXCLUSIONS

- » Athletic mouth guards and jaw function services, bite registration or analysis, or any related services.
- » Any temporary service.
- » Any pre- and/or post-operative services.
- » Allowance for an assistant surgeon.
- » Services delivered for treatment of birth or developmental defects.
- » Conscious sedation, general anesthetics, analgesia, I.V. sedation and other patient management services.
- » Any amalgam, composite, interim therapeutic or protective fillings.
- » Any pin retention or post placement.
- » Any prefabricated stainless steel, resin or porcelain crowns.
- » Any service provided primarily for cosmetic purposes.
- » Any service to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction will not be compensated.
- » Any service delivered as a result of improper alignment, occlusion or contour.
- » Any root canal therapy.
- » Any apexification/recalcification procedures.
- » Any apicoectomy, retrograde filling, root amputation or hemisection procedures.
- » Any periodontal scaling or maintenance procedures.
- » Any crown lengthening, bone surgery or soft tissue surgery procedures.
- » Any services for grafting procedures.
- » Any service related to periodontal stabilization of teeth (splinting) will not be compensated.
- » Any tooth removal services.

- » Any alveoloplasty procedures.
- » Any re-cementation, repairs or adjustments to crowns, inlays, onlays, fixed bridges, partial dentures or complete dentures.
- » Any core buildup, crown, inlay, onlay, veneer, implant or fixed bridge.
- » Any partial denture or complete denture.
- » Any occlusal guard or occlusal orthotic device.
- » Any service delivered when due to the patient's condition would not prove successful to improve the patient's oral health.
- » Any service delivered when provided in anticipation of future need (except covered preventive services).
- » Any services to replace lost, stolen or damaged items.
- » Any services to repair items altered by someone other than a provider.
- » Any services provided for treatment of teeth retained in relation to an overdenture.
- » Charges for prescribed drugs.
- » Any experimental or Investigational treatment.
- » Hospital costs or any charges for use of any facility.
- » House/extended care facility call, hospital or ambulatory surgical center call.
- » Interim complete dentures.
- » Implant/abutment supported interim fixed denture for edentulous arch.
- » Therapy for speech or the function of the tongue or face.
- » Coping used as a definitive restoration.
- » Anatomical crown exposure and any related services.
- » Pulpal regeneration and any related services.
- » Bone graft, biologic materials, tissue regeneration with periradicular surgery and any related services.
- » Connector bar or pediatric partial denture and any related services.
- » Any orthodontic services.
- » Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment services.
- » Tomographic survey.
- » 3D photographic images.
- » Image capture and/or interpretation for cone beam, MRI, ultrasound or sailoendoscopy.
- » Implant index.
- » Sample collection.
- » Any vestibuloplasty.
- » Any maxillofacial prosthetics services.
- » Any surgical repositioning of teeth, osteoplasty, osteotomy, LeFort procedures.
- » Any complicated suturing and reconstruction services.
- » Any transplantation or re-implantation services.
- » Any placement of temporary anchorage device.

- » Any harvest of bone.
- » Any corticotomy.
- » Precision attachment and any related services.
- » Repair or relining of occlusal guard and any other related services.
- » Teaching services.
- » Completion of forms. Providing diagnostic information. Copying of records. Sales tax. Translation services.
- » Missed/cancelled appointment charges.
- » Preventive and plaque control programs, including home care items.
- » Provisional splinting.
- » Internal and external bleaching.
- » Any services not included in covered services.