

**DELTA CARE DENTAL PLAN, INC.**

**DENTAL ONLY COVERAGE**

**OUTLINE OF COVERAGE**

**(1) Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

**(2) Dental Only Coverage.** Policies of this category are designed to provide, to persons covered, **DENTAL ONLY** coverage.

**(3) Brief Description of Benefits.** This dental program provides a comprehensive set of Benefits including diagnostic, preventive, restorative, endodontic, periodontic, oral surgery, prosthetic and orthodontic procedures. Some procedures are provided at no cost while others have fixed copayment amounts. Below is an abbreviated listing of Benefits for informational purposes only. Refer to the contract for a comprehensive Description of Benefits and Copayments on pages 10 through 17.

Diagnostic

Oral evaluations .....	No Cost
Bitewing x-rays - four films - 1 series every 6 months .....	No Cost
Office Visit .....	\$ 5.00

Preventive

Prophylaxis cleaning - adult - 1 per 6 month period .....	\$ 25.00
Prophylaxis cleaning - child - 1 per 6 month period .....	\$ 25.00
Topical application of fluoride (including prophylaxis)	
- child -to age 19; 1 per 6 month period .....	\$ 25.00
Sealant - per tooth - limited to permanent molars through age 15 .....	\$ 20.00
Space maintainer - fixed - bilateral .....	\$ 150.00

Restorative

Amalgam - one surface, primary or permanent .....	\$ 37.00
Resin-based composite - one surface, anterior .....	\$ 65.00
Inlay - metallic - one surface .....	\$260.00
Onlay - metallic - two surfaces .....	\$270.00
Crown - porcelain fused to noble metal .....	\$325.00
Crown repair .....	\$ 50.00

Endodontics

Pulp cap - direct (excluding final restoration) .....	\$ 25.00
Therapeutic pulpotomy (excluding final restoration) .....	\$ 45.00
Root canal - molar (excluding final restoration) .....	\$400.00
Retrograde filling - per root .....	\$ 65.00

Periodontics

Gingivectomy or gingivoplasty .....	\$260.00
Osseous surgery .....	\$650.00
Periodontal scaling and root planing	
- limited to 4 quadrants during any 12 consecutive months .....	\$ 80.00
Periodontal maintenance	
- limited to 1 treatment each 6 month period .....	\$ 50.00

Prosthodontics (removable and fixed)

Complete denture - maxillary / mandibular .....	\$450.00
Maxillary /mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .....	\$550.00
Adjustments dentures / partials .....	\$ 20.00
Repair broken complete denture base .....	\$ 50.00
Relines (chairside) .....	\$ 50.00
Relines (laboratory) .....	\$150.00
Pontic - cast noble metal .....	\$325.00
Crown - full cast noble metal .....	\$325.00
Stress breaker .....	\$ 50.00
Cast post and core in addition to fixed partial denture retainer - includes canal preparation .....	\$110.00

Oral and Maxillofacial Surgery

Single tooth - simple extraction .....	\$ 40.00
Removal of impacted tooth - soft tissue .....	\$100.00

Removal of impacted tooth - partially bony .....	\$ 170.00
Removal of impacted tooth - completely bony .....	\$ 210.00
Surgical removal of residual tooth roots (cutting procedure) .....	\$ 75.00
Incision and drainage of abscess - intraoral soft tissue .....	\$ 35.00

### Orthodontics

Comprehensive orthodontic treatment of the transitional or adolescent dentition - child or adolescent to age 19 (24 months of treatment) .....	\$2,600.00
Comprehensive orthodontic treatment of the adult dentition - adults, including dependent adult children from age 19 to 26 (24 months of treatment) .....	\$2,800.00
Orthodontic retention (removal of appliances, construction and placement of retainers) (24 months of retention) .....	\$ 250.00
Start-up fees (includes initial examination, diagnosis, consultation and initial banding) .....	\$ 200.00

### Adjunctive General Services

Palliative (emergency) treatment of dental pain - minor procedure .....	\$ 35.00
Local anesthesia .....	No Cost
Consultation (diagnostic services provided by dentist or physician other than practitioner providing treatment) .....	\$ 50.00
Office visit for observation (during regularly scheduled hours) - no other services performed .....	\$ 5.00
Office visit - after regularly scheduled hours .....	\$ 50.00
Failed appointments without 24-hour notice - per 15 minutes of appointment time .....	\$ 15.00

- (4) Limitations and Exclusions of Benefits.** The limitations and exclusions describe how often services will be provided under the dental program, and what types of services are not covered. These are also found on pages 18 through 24 of the contract.

### Limitations of Benefits

1. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
2. Bitewing x-rays are limited to not more than one series of four films in any six month period;

3. *Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits;*
4. *Prophylaxis or periodontal maintenance is limited to one procedure each six-month period;*
5. *Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.*
6. *Amalgams and composites are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration;*
7. *The placement of a crown, inlay or onlay is a benefit when there is insufficient tooth structure to support a filling. Replacement of an existing crown, inlay or onlay that is non functional or non restorable is a benefit when the existing restoration is five + years old;*
8. *If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is \$75.00;*
9. *A covered metallic inlay, onlay, and cast post and core using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is \$100.00 per tooth;*
10. *For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is \$150.00 per molar;*
11. *A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth;*
12. *With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth with pathology;*
13. *A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy;*
14. *Periodontal scaling and root planing are limited to four quadrants during any 12 month period;*

15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period;
16. Coverage for the placement of a fixed partial denture (“bridge”) is limited to:
- a. The initial placement of a bridge when all the following conditions are present:
    - a single permanent tooth requires prosthetic replacement;
    - the abutment teeth can adequately support and retain a new bridge;
    - the missing tooth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture;
    - no other missing teeth in the same arch require prosthetic replacement with a new removable partial denture; and (for a bridge replacing a posterior tooth) one or more of the abutment teeth meet Limitation #7;
  - b. The replacement of an existing bridge that is not serviceable due to decay, fracture or other non-cosmetic defect, if:
    - the existing bridge is at least five years old; **and**
    - the same abutment teeth can adequately support and retain a new bridge; **and**
    - no other missing teeth in the same arch require prosthetic replacement;
17. Coverage for a new removable partial or complete denture is limited to:
- a. The initial placement of removable partial or complete denture in an arch when:
    - one or more permanent teeth require prosthetic replacement; **and**
    - the missing tooth/teeth cannot be replaced by adding a prosthetic tooth to a serviceable existing removable partial denture; **and**
    - (for partial dentures only) there are suitable abutment teeth to retain and support a removable partial denture;
  - b. The replacement of an existing removable partial or complete denture with non-cosmetic defect(s) that cause the denture to be non-serviceable if:
    - the existing removable denture is at least five years old; **and**
    - the existing removable denture cannot be made serviceable by adjustment, repair, relining or rebasing;
18. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months;
19. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
- a. The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture; **or**
  - b. The replacement of permanent tooth/teeth for children under 16 years of age;

20. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered;
21. Retained primary teeth shall be covered as primary teeth;
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance;
23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by DeltaCare, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
24. Soft tissue management programs include but are not limited to periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for covered services;

#### Exclusions of Benefits

1. Any procedure that is not specifically listed under Description of Benefits and Copayments;
2. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
3. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age;
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges);
5. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ);
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures;

7. *An initial treatment plan that involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered benefits. This exclusion does not eliminate the benefit for other covered services;*
8. *Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;*
9. *Extraction/removal of an erupted, partially erupted or impacted tooth:*
  - a. *Solely for orthodontic purposes;*
  - b. *When the tooth exhibits no signs or symptoms of infection, cystic degeneration, fracture, caries and/or having caused damage to an adjacent tooth; **or***
  - c. *When the extraction or removal would be inconsistent with generally accepted professional standards;*
10. *Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent;*
11. *Consultations for non-covered benefits;*
12. *Replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or better match bleached teeth;*
13. *Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by DeltaCare or as cited under Emergency Services. To obtain written authorization, you should call the Customer Relations department at (800) 422-4234;*
14. *Any procedure that in the professional opinion of the Contract Dentist:*
  - a. *has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or***
  - b. *is inconsistent with generally accepted standards for dentistry;*
15. *All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;*
16. *Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities;*
17. *Dispensing of drugs not normally utilized in the delivery of dental services;*

18. *Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics;*
19. *Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage;*
20. *Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is paid. Services that are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision;*
21. *Treatment required by reason of war declared or undeclared;*
22. *Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;*
23. *Accidental injury. Accidental injury is defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of Benefits.*

#### Orthodontic Limitations

*The DeltaCare program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. Start-up fees, retention fees, and the cost to the Enrollee for the treatment plan are listed in the Description of Benefits and Copayments, and are subject to the following:*

1. *Orthodontic treatment must be provided by the selected Contract Orthodontist;*
2. *Orthodontic Copayments are listed in the Description of Benefits and Copayments, for comprehensive orthodontic treatment. Additional fees will be charged for start-up and retention;*
3. *Benefits cover 24 months of active comprehensive orthodontic treatment, including initial banding, de-banding and any commonly used appliances such as headgear;*
4. *Following benefited comprehensive orthodontic treatment, retention is covered up to a maximum of 24 months. Retention includes the initial construction, placement and adjustment to removable retainers and office visits;*
5. *Treatment plans extending beyond 24 months of active comprehensive orthodontic treatment, or 24 months of retention, will be subject to a monthly office visit fee to the Enrollee not to exceed \$125.00 per month;*

6. *Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall increase to a maximum of the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;*
7. *If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$85.00 in addition to diagnostic record fees;*
8. *Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee;*
9. *The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:*
  - a. *will not be entitled to a refund of any amounts previously paid, and*
  - b. *will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.*

#### Orthodontic Exclusions

1. *Pre-, mid- and post-treatment records that include cephalometric x-rays, tracings, photographs and study models;*
2. *Lost, stolen or broken orthodontic appliances;*
3. *Changes in treatment necessitated by accident of any kind and/or lack of Enrollee cooperation;*
4. *Surgical procedures incidental to orthodontic treatment;*
5. *Myofunctional therapy;*
6. *Surgical procedures related to cleft palate, micrognathia or macrognathia;*

7. *Treatment related to temporomandibular joint disturbances;*
8. *Supplemental appliances not routinely used in comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix, or Herbst;*
9. *Restorative work caused by orthodontic treatment;*
10. *Interceptive orthodontics\*, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;*
11. *Extractions solely for the purpose of orthodontics;*
12. *Treatment in progress at inception of eligibility;*
13. *Patient initiated transfer after bands have been placed;*
14. *Composite or ceramic brackets, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.*

\* *Interceptive orthodontics is defined as early treatment including orthodontia prior to the development of late mixed dentition.*

**(5) Renewability and Age Restrictions.** No change in Benefits or Premium will be made during a Contract Term (one year). We will send a written renewal notice, including any proposed changes in Benefits and/or Premium at least 60 days before coverage expires. Coverage terminates at the end of the Contract Term unless the applicable Premium is paid on or before the expiration date of the Contract, or prior to the end of the 30-day grace period.

Unmarried dependent children are eligible from birth to age 26. However, an unmarried child over age 26 may remain eligible if that child is incapable of self-support because of a physical disability or mental incapacity and is chiefly dependent on the Primary Enrollee for support and maintenance.