Delta Dental of Iowa

DELTA DENTAL PPO PLUS PREMIER®

INDIVIDUAL CHOICE - PREVENTIVE PLUS

REQUIRED OUTLINE OF COVERAGE

A. **Read Your Policy Carefully**. This Outline of Coverage provides a very brief description of some 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 you, your dentist and Delta Dental of Iowa. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This Policy is a certified Qualified Health Plan in the Health Insurance Marketplace.

B. This dental plan is designed to provide an Eligible Covered Person, who is over age 21 as of January 1, with coverage for diagnostic and preventive benefits. This dental plan is also designed to provide an Eligible Covered Person, who is under age 21 as of January 1, with comprehensive care related to pediatric essential health benefits.

C. **BENEFITS -** The information in the two charts below summarizes your benefits and payment obligations.

Adult Chart – This chart is for all Eligible Covered Persons age 21 and older as of January 1st.

	DEDUCTIBLE APPLIES*	COINSURANCE	ANNUAL MAXIMUM APPLIES
BENEFIT CATEGORIES	$50 PPO $50 Premier $75 Non-Par		Unlimited
Check-Ups and Teeth Cleaning (Diagnostic and Preventative Services)	Yes	20% - PPO 30% - Premier 50% - Non-Par	Yes
Cavity Repair (Routine and Restorative Services)	Yes	50% - PPO 50% - Premier 70% - Non-Par	Yes

*** Deductible is per Eligible Covered Person per Benefit Period.**

Child Chart - This chart is for all Eligible Covered Persons under age 21 as of January 1.

	DEDUCTIBLE APPLIES*	MEMBER COINSURANCE	MAXIMUM OUT OF POCKET APPLIES**
Benefit Categories	$75 PPO $75 Premier $225 Non Par		$350 / $700 – PPO and Premier N/A – Non Par
Check-ups and Teeth Cleanings (Diagnostic and Preventive)	No	00% - PPO 50% - Premier 50% - Non Par	Yes
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Posterior Composites (Tooth-colored filling on back teeth)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Root Canals (Endodontic Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Gum and Bone Disease (Periodontal Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
High Cost Restorations (Cast Restorations)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dentures and Bridges (Prosthetics)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dental Implants (Prosthetics)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Straighter Teeth – **Medically Necessary Orthodontics**	Yes	50% - PPO 50% - Premier 50% - Non Par	Yes

***Deductible is per Eligible Covered Person per Benefit Period.**

****Maximum Out Of Pocket is per eligible Child with a maximum amount for all eligible covered children for PPO Panel Dentists and/or Participating Delta Dental Dentists (Premier).**

D. **LIMITATIONS – Adult**

1. **Dental Cleaning (Prophylaxis)** - *Limitation:* Routine dental cleaning is a benefit only twice per Benefit Period.

2. **Oral Evaluations -** *Limitation*: This evaluation is a benefit only twice per Benefit Period.

3. **Bitewing X-Rays -** *Limitation:* For an Eligible Covered Person, who is age 21 or older as of the Anniversary Date, bitewing x-rays are a benefit once every 24 consecutive months if there is no history of restorations in the previous 24 months. If there is a history of restorations in the previous 24 months, bitewing x-rays are a benefit once every 12 consecutive months.

4. **Full-Mouth X-Rays -** *Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

5. **Occlusal and Extraoral X-Rays -** *Limitation:* These x-rays are a benefit only once every 12 consecutive months.

6. **Limited Occlusal Adjustment** - *Limitation:* Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

E. **EXCLUSIONS – Adult –** Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Policy. Call us if you are unsure if a certain service is covered.

1. **Anesthesia or Analgesia -** You are not covered for general anesthesia, intravenous sedation, local anesthesia, non-intravenous conscious sedation, or nitrous oxide (relative analgesia).

2. **Broken Appointments -** You are not covered for any fees charged by your dental office because of broken appointments.

3. **Complete Occlusal Adjustment** - You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

4. **Complications of a Non-Covered Procedure** - You are not covered for complications of a non-covered procedure.

5. **Congenital Deformities** - You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

6. **Controlled Release Device** - You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

7. **Cosmetic in Nature** - You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

8. **Desensitizing Medicament or Resin -** You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

9. **Drugs -** You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

10. **Effective Date -** You are not covered for services or supplies received before the effective date of coverage under this Policy.

11. **Endodontics -** You are not covered for endodontic services including apicoectomy/periradicular surgery, direct or indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy.

12. **Experimental or Investigative -** You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

13. **Government Programs -** You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

14. **Gum and Bone Diseases (Periodontal Services)** – You are not covered for services or supplies for periodontal services including conservative, complex, or maintenance periodontal procedures.

15. **High Cost Restorations (Cast Restorations)** – You are not covered for services or supplies for cast restoration services, including crowns, inlays, and onlays.

16. **Implants -** You are not covered for any dental implants which are surgically placed in the jawbone. You are also not covered for the attachment of any device to a surgically placed implant in the jawbone.

17. **Incomplete Services -** You are not covered for dental services that have not been completed.

18. **Indirect Pulp Caps -** You are not covered for indirect pulp caps.

19. **Infection Control -** You are not covered for separate charges for "infection control," which includes the costs for services and supplies associated with sterilization procedures. Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for "infection control."

20. **Lost or Stolen Appliances -** You are not covered for services or supplies required to replace lost or stolen dental appliances.

21. **Medical Services or Supplies -** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

22. **Military Service -** You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services. However, upon written request, you may ask for a refund of premiums that you have paid while on active military status.

23. **Oral Surgery -** You are not covered for oral surgery including removal of teeth, and other surgical services to the teeth.

24. **Payment Responsibility** - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would not be charged.

25. **Periodontal Appliances -** You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

26. **Periodontal Splinting -** You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

27. **Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions –** You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

28. **Policy Termination** - Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this Policy.

29. **Prosthetics (Bridges, Dentures, and Dental Implants)** – You are not covered for services or supplies used for prosthetics including bridges, dentures, and dental implants.

30. **Provisional Crowns, Bridges or Dentures** - You are not covered for services or supplies for provisional crowns, bridges or dentures.

31. **Repair, Replacement or Duplication of Orthodontic Appliances** - You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

32. **Root Canals (Endodontics) -** You are not covered for endodontic services including apicoectomy/periradicular surgery, direct and indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy

33. **Sealants/Preventive Resin Applications** - You are not covered for services or supplies for sealant/preventive resin applications.

34. **Services Not Reimbursed to Some Extent by Delta Dental –** You are not covered for any services that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

35. **Services Provided in Other Than Office Setting -** You are not covered for services provided in other than a dental office setting.

36. **Space Maintainers –** You are not covered for space maintainers for missing back teeth or the removal of fixed space maintainers.

37. **Specialized Services -** You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

38. **Straighter Teeth – Corrective Orthodontics –** You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

39. **Straighter Teeth – Medically Necessary Orthodontics –** You are not covered for Medically Necessary Orthodontic services. Medically Necessary Orthodontic services are orthodontic

procedures benefited because of needed orthognathic surgery, certain designated syndromes of genetic disorders such as cleft palate.

40. **Temporary or Interim Procedures** - You are not covered for temporary or interim procedures.

41. **Temporomandibular Joint Dysfunction (TMD) -** You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction or myofunctional therapy.

42. **Tissue Conditioning –** You are not covered for services or supplies pertaining to tissue conditioning.

43. **Tooth Extractions –** You are not covered for tooth extractions.

44. **Treatment By Other Than A Licensed Dentist -** You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees.

45. **Unerupted Teeth -** You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

46. **Workers' Compensation -** You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any Deductible under your employer's Workers' Compensation coverage.

F. LIMITATIONS – Child

1. **Dental Cleaning (Prophylaxis)** – *Limitation:* Routine dental cleaning is a benefit only twice per Benefit Period.

2. **Oral Evaluations –** *Limitation*: This evaluation is a benefit only twice per Benefit Period.

3. **Topical Fluoride Applications –** *Limitation:* Topical fluoride is a benefit only twice per Benefit Period.

4. **Bitewing X-Rays –** *Limitation:* Bitewing x-rays are a benefit only twice per Benefit Period.

5. **Full-Mouth X-Rays –** *Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

6. **Occlusal and Extraoral X-Rays –** *Limitation:* These x-rays are a benefit only once every 12 consecutive months.

7. **Periodontal Maintenance Therapy** – *Limitation:* This procedure may follow conservative or complex periodontal therapy; benefits are available up to four times in the first Benefit Period and twice per Benefit Period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described earlier in this section.*

8. **Sealant/Preventive Resin Applications** – *Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars every 36 consecutive months. Sealants and Preventive Resins for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration are not a benefit.

9. **Conservative Periodontal Procedures (Root Planing and Scaling) -** *Limitation:* Conservative periodontal procedures are a benefit only once every 24 consecutive months for each quadrant of the mouth.

   Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

10. **Denture Adjustments -** *Limitation:* Denture Adjustments will be limited to two per denture per Benefit Period after 6 months have elapsed since initial placement.

11. **Denture Rebase / Relining -** *Limitation:* Rebase and relining are available only if performed 6 months or more after the initial placement of the denture then once every 3 consecutive years thereafter.

12. **General Anesthesia/Sedation –** *Limitation:* General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

13. **Restoration of Decayed or Fractured Teeth** – *Limitation:* Stainless steel crowns are a benefit for an Eligible Covered Person, who is under age 15 as of January 1, once per tooth every 5 consecutive years.

14. **Tissue Conditioning -** *Limitation:* Tissue conditioning will be limited to two per denture every 36 consecutive months.

15. **Root Canal Therapy –** *Limitation:* Pulpal Therapy is limited to once per tooth per lifetime.

16. **Full Mouth Debridement** – *Limitation:* Full mouth debridement is a benefit once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).

17. **Complex Periodontal Procedures** – *Limitation:* Complex periodontal procedures are a benefit only once every 3 consecutive years for each quadrant of the mouth for natural teeth only. In addition, **you should receive Delta Dental's review before this service is performed.**

    Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

18. **Periodontal Appliances –** *Limitation:* Periodontal appliance is a benefit only for an eligible Child age 13 to 20 once per Benefit Period. In addition, **you should receive Delta Dental's review before this service is performed.**

19. **Cast Restorations for Complicated Tooth Decay or Fracture** – *Limitation:* Available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

20. **Crowns** – *Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling. Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place. In addition, **you should receive Delta Dental's review before this service is performed.**

21. **Inlays** – *Limitation:* Inlay benefits are limited to the amount paid for a silver (amalgam) filling and available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

22. **Onlays** – *Limitation:* Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

23. **Posts and Cores** – *Limitation:* Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

24. **Bridges** – *Limitation:* Bridges (prosthetics) are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

25. **Dentures (Complete and Partial)** – *Limitation:* Dentures (prosthetics) are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

26. **Dental Implants** – *Limitation:* Dental implants are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

27. **Straighter Teeth – Medically Necessary** - *Limitation:* Services for 'Medically Necessary' Orthodontic straightening of the teeth. ***"Medically Necessary"*** Orthodontic is orthodontic procedures and Covered Services benefited because of needed orthognathic surgery, certain designated syndromes or genetic disorders such as cleft palate. **Please Note**: Medically Necessary Orthodontics ***REQUIRES*** our review and approval before treatment begins. Benefits received from 'Medically Necessary' Orthodontics may apply to the Maximum Out Of Pocket.

G. **EXCLUSIONS – Child** - Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Policy. Call us if you are unsure if a certain service is covered.

1. **Anesthesia or Analgesia** - You are not covered for , local anesthesia, nitrous oxide (relative analgesia), or non-intravenous conscious sedation when billed separately from the related procedure.

2. **Broken Appointments** - You are not covered for any fees charged by your dental office because of broken appointments.

3. **Complete Occlusal Adjustment** - You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

4. **Complications of a Non-Covered Procedure** - You are not covered for complications of a non-covered procedure.

5. **Congenital Deformities** - You are not covered for services or supplies to correct congenital deformities, unless you qualify under Medically Necessary Orthodontics.

6. **Cosmetic in Nature** - You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

7. **Desensitizing Medicament or Resin** - You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

8. **Drugs** - You are not covered for prescription, non-prescription drugs, or medicines.

9. **Effective Date -** You are not covered for services or supplies received before the effective date of coverage under this Policy.

10. **Experimental or Investigative -** You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

11. **Government Programs -** You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

12. **Incomplete Services -** You are not covered for dental services that have not been completed.

13. **Indirect Pulp Caps -** You are not covered for indirect pulp caps.

14. **Infection Control -** You are not covered for separate charges for "infection control," which includes the costs for services and supplies associated with sterilization procedures. Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for "infection control."

15. **Limited Occlusal Adjustment –** You are not covered for limited occlusal adjustment.

16. **Lost or Stolen Appliances -** You are not covered for services or supplies required to replace lost or stolen dental appliances.

17. **Medical Services or Supplies -** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

18. **Military Service -** You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

19. **Payment Responsibility** - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would n**o**t be charged.

20. **Periodontal Appliances -** An Eligible Covered Person, who is under 13 or over 20 years of age as of January 1, is not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching

21. **Periodontal Splinting -** You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

22. **Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions –** You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

23. **Policy Termination -** Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this Policy.

24. **Provisional Crowns, Bridges or Dentures** - You are not covered for services or supplies for provisional crowns, bridges or dentures.

25. **Repair, Replacement or Duplication of Orthodontic Appliances** - You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

26. **Services Not Reimbursed to Some Extent by Delta Dental –** You are not covered for any services that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

27. **Services Provided in Other Than Office Setting** - You are not covered for services provided in other than a dental office setting.

28. **Space Maintainer Removal –** You are not covered for the removal of fixed space maintainers.

29. **Specialized Services** - You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

30. **Straighter Teeth – Corrective Orthodontics –** You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

31. **Straighter Teeth – Medically Necessary Orthodontics –** An Eligible Covered Person, who is age 21 or older as of January 1, is not covered for Medically Necessary Orthodontics.

32. **Temporary or Interim Procedures** - You are not covered for temporary or interim procedures.

33. **Temporomandibular Joint Dysfunction (TMD)** - You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction or myofunctional therapy.

34. **Treatment By Other Than A Licensed Dentist** - You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees.

35. **Unerupted Teeth** - You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

36. **Workers' Compensation** - You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any Deductible under your employer's Workers' Compensation coverage.

H. **POLICY RENEWAL** – Your coverage under the Policy will continue unless one of the following events occurs:

1. You fail to make your premium payment to us when due.
2. You become ineligible for coverage under the Policy.
3. You decide to discontinue or replace this coverage - *Delta Dental of Iowa requires at least **20-day written** notice prior to the requested termination.*
4. We decide to terminate coverage of all similar Policies by giving written notice to you 90 days prior to termination.

5. You use the Policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
6. You are no longer a permanent resident of Iowa.

I. **PREMIUMS** – You must pay us the full amount of your premium in advance of the due date assigned for your Policy. For example, payment must be made prior to the beginning of each calendar month, via automatic withdrawal (ACH) from a checking or savings account or with a valid credit card (American Express, Discover Card, Master Card, or VISA).

J. **OTHER INFORMATION –**

Claims filing address – Delta Dental of Iowa; P.O. Box 9000; Johnston, IA 50131-9000
Hearing Impaired Toll Free – 1 – 888 – 287- 7312
Toll Free – 1 – 800 – 544 – 0718 **Local –** 1– 515 – 261 – 5500
Delta Dental of Iowa's website –

- www.deltadentalia.com
- claims@deltadentalia.com
- individualproduct@deltadentalia.com