

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS – PEDIATRIC DENTAL PLAN A AND PLAN B ADULT/FAMILY DENTAL PLANS – ADULT PLANS A-G

BRIEF SUMMARY OF EXCLUSIONS AND LIMITATIONS

Refer to your Delta Dental of Nebraska Dental Benefit Plan Summary for complete details

This summary of exclusions and limitations is provided for your convenience and is not intended to be a complete description. Only those services and supplies specifically listed in the Dental Benefit Plan Summary are covered under the plan, regardless of dental necessity.

The Dental Benefit Plan Summary is your source for complete information, including the specific dental treatments that are covered, the frequency with which those treatments are covered, benefit amounts, limitations, exclusions, waiting periods and conditions under which coverage may remain in force.

EXCLUSIONS

Coverage is not provided for:

- Dental services that a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.
- Dental services or health care services not specifically covered under your Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the plan, an established scientific basis for recommendation.
- Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment, and the member is responsible for the full charge.
- Dental services completed prior to the date the Covered Person became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- Dental services performed other than by a licensed dentist, licensed physician or his/her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

- Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- Case presentations, office visits and consultations.
- Incomplete, interim or temporary services.
- Corrections of congenital conditions during the first 24 months of continuous coverage under this plan.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- Procedures designed to enable prosthetic or restorative services to be performed, such as a crown lengthening.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
- Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Oral hygiene instruction.
- Restorative cast post/core or core build-up, including pins and posts.
- Occlusal procedures, including occlusal guard and adjustments.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Implant maintenance or repair to an implant or implant abutment.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Diagnostic casts.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.

- Temporary anchorage devices.
- Sinus augmentation.
- Brush biopsy and the accession of a brush biopsy.
- Restorations placed for preventive or cosmetic purposes.
- Inlays, onlays and crowns placed for preventive or cosmetic purposes.
- Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

LIMITATIONS

- a) **Optional Treatment Plans:** In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
- b) **Reconstructive Surgery:** Benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly that has resulted in a functional defect as determined by the attending physician, provided however, that such services are dental reconstructive surgical services.

This is only an overview. For complete exclusions and limitations, please refer to the Description of Coverages section in the Dental Benefit Plan Summary.

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