

# Standard Processing Policies

## (For groups renewing July 2011 or later)

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**Please note that some groups are non-standard. The Group Limitation over rides the Standard Processing Policies**

### Covered Dental Services and Limitations

▶ [Class I Services](#)

▶ [Class II Services](#)

▶ [Class III Services](#)

[Exclusions](#)

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## BENEFITS AND LIMITATIONS

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These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

### Class I Services

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#### Diagnostic

a. **Diagnostic Services:**

- i. Examination
- ii. Intra-oral x-rays to assist in determining required dental treatment.

**Diagnostic Limitations:**

Periodic (routine), comprehensive exams or consultations	1 per 6 months
Complete series x-rays or a panoramic film	1 per 5 years
Bitewing x-rays	1 per 12 months

b. **Diagnostic Limitations:**

- i. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period\*.
- ii. Complete series x-rays or a panoramic film is covered once in any 5-year period\*.
- iii. Supplementary bitewing x-rays are covered once in any 12-month period\*.
- iv. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
- v. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
- vi. ViziLite Plus TBlue is covered once in any 6-month period\*.

## Preventive

### a. Preventive Services:

- i. Prophylaxis (cleanings)
- ii. Periodontal maintenance
- iii. Topical application of fluoride
- iv. Space maintainers
- v. Sealants

### b. Preventive Limitations:

Prophylaxis or Periodontal Maintenance	1 per 6 months
Topical fluoride	1 per 6 months
Sealant	1 per 5 years
Space Maintainers	1 per space

- i. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period\*†.

†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see SECTION 6).

- ii. Topical application of fluoride is covered once in any 6- month period\* for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period\* if there is a history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
- iii. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
- iv. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for members age 14 or over are not covered.

\* Note:

These time periods are calculated from the previous date of service.

## Class II Services

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## Restorative

### a. Restorative Services:

- i. Provides amalgam fillings on posterior teeth and composite fillings on anterior teeth for the treatment of carious lesions (decay).

### b. Restorative Limitations:

- i. Inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided.
- ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.

- iii. Additional limitations when teeth are restored with crowns or cast restorations are in section 5.3.1.
- iv. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.
- v. Composite, resin, or similar (tooth colored) restorations in posterior teeth are considered optional services. Coverage shall be made for a corresponding amalgam restoration. **If a composite filling is used to restore posterior teeth, benefits are limited to the amount paid for an amalgam filling. The member is responsible for paying the difference.**

**Oral Surgery**

- a. **Oral Surgery Services:**
  - i. Extractions (including surgical),
  - ii. Other minor surgical procedures,
  - iii. General anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).
- b. **Oral Surgery Limitations:**
  - i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
  - ii. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
  - iii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
  - iv. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

**Endodontic**

- a. **Endodontic Services:**
  - i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).
- b. **Endodontic Limitations:**
  - i. A separate charge for cultures is not covered.
  - ii. Pulp capping is covered only when there is exposure of the pulp.
  - iii. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

**Periodontic**

- a. **Periodontic Services:**
  - i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

**b. Periodontic Limitations:**

Periodontal scaling and root planing	1 per quad per 24 months
Full mouth debridement	1 per 3 years

- 1. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.

2. Coverage for periodontal maintenance procedure under Class I, Preventive.
3. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

## Class III Services

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### Restorative

**a. Restorative Services:**

- i. Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

**b. Restorative Limitations:**

Cast restorations	1 per 7 years
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- i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See section 5.2 for limitations on buildups.
- ii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
- iii. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

### Prosthodontic

**a. Prosthodontic Services:**

- i. Bridges,
- ii. Partial and complete dentures,
- iii. Denture relines,
- iv. Repair of an existing prosthetic device
- v. Implants

**b. Prosthodontic Limitations:**

Crown, Bridge, Denture, or Partial	1 per 7 years
Relines	1 per 12 months
Adjustments	2 per 12 months

- i. A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
- ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is

used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.

- iv. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
- v. Tissue conditioning is covered no more than twice per denture in a 36-month period.
- vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The Plan will also benefit:
  - A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
  - B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or
  - C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period.
  - D. Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth.
  - E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.
- vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
- viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

### **General Limitation – Optional Services**

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the fee.

### **Non-Participating Dental Dentists**

The amounts payable for services of a non-participating dentist are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating dentist fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance.

# EXCLUSIONS

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In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise dentally necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a dental provider.

## **Anesthesia or Sedation**

The Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.

## **Anesthetics, Analgesics, Hypnosis, and Medications**

Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs are excluded.

## **Benefits Not Stated**

Exclusions include all other services or supplies not specifically included in this handbook as covered dental services under the Plan.

## **Claims Not Submitted Timely**

Claims submitted more than one year after the date of service are not covered, except as stated in section 11.1.

## **Congenital or Developmental Malformations**

Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.

## **Cosmetic**

Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.

## **Experimental Procedures**

Experimental procedures or supplies are excluded.

## **Facility Fees**

Hospital or facility charges for services or supplies, or additional fees charged by the dentist for hospital, extended care facility or home care treatment are excluded.

## **Gnathologic Recordings**

Gnathologic recordings or similar procedures are excluded.

## **Instructions or Training**

Plaque control and oral hygiene or dietary instruction are not covered.

## **Localized Delivery of Antimicrobial Agents**

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.

**Missed Appointments**

Charges for missed or broken appointments are excluded.

**Orthodontia**

Orthodontic services (treatment of malalignment of teeth and/or jaws) are excluded.

**Periodontal Charting**

A separate charge for periodontal charting is not covered.

**Precision Attachments****Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth**

Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

**Services on Tongue, Lip, or Cheek**

Services performed on the tongue, lip or cheeks are not covered.

**Services Otherwise Available**

This exclusion includes:

- Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
- Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
- Services which are provided, without cost to the member, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan; or
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the member enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto, is excluded.

**Services Provided By a Relative**

ODS will not reimburse services provided by members or their relatives. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

**Taxes****Third Party Liability Claims**

Services and supplies for treatment of illness or injury for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party. This includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. (See section 11.3).

**TMJ**

Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.

**Treatment After Coverage Terminates**

The Plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends. This provision is not applicable if the Group transfers its plan to another carrier.

**Treatment Before Coverage Begins**

Dental services started prior to the date the member became eligible for such services under the Plan are excluded.

**Treatment Not Dentally Necessary**

The Plan does not cover:

- Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan;
- Services that are inappropriate with regard to standards of good dental practice;
- Services with poor prognosis.