Summary Plan Description

Table of Contents

Important Notice 2

Eligibility for Dental Coverage
- Elected Official/Employee Coverage 2
- Dependent Coverage 3

Dental Expense Insurance
- Covered Charges 5
- Alternate Treatment 6
- Proof of Claim 6
- Pre-Treatment Review 6
- Benefits from Other Sources 7
- After This Insurance Ends 7
- Special Limitations 7
- Exclusions 7
- List of Covered Dental Services 9
- Group I - Preventive Dental Services 9
- Group II - Basic Dental Services 10
- Group III - Major Dental Services 14
- Group IV - Orthodontic Services 16

Network Access 16

Coordination of Benefits
- Definitions 17
- Order of Benefit Determination 19
- Effect on the Benefits of this Plan 20
- Right to Receive and Release Needed Information 21
- Facility of Payment 21
- Right of Recovery 21

Subrogation and Right Of Recovery 21

Glossary 24
- Delta Dental's Responsibilities 26
- Termination of this Group Plan 26

Important Notice

As used in this book, the terms:

- ☐ Certificate refers to this book describing the benefits directly funded through and provided by your employer;
- ☐ Insurance and Insured refers to the benefits directly funded through and provided by your employer;
- ☐ Plan, We, Us and Our refer to the benefits that are directly funded through and provided by your employer;
- ☐ Premium, Premiums, and Premium Charge refer to payments required from you for coverage under this plan; and
- ☐ Proof of Insurability refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this book will be applicable to these benefits provided by your employer.

The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Eligibility for Dental Coverage

Elected Official/Employee Coverage

To be eligible for employee coverage, you must be an Elected Official or active full-time employee. And you must belong to a class of employees covered by this plan.

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

But you must be actively at work on a full-time basis on the scheduled effective date. And you must have met all of the applicable conditions explained above. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active full-time work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a full-time basis on your last regularly scheduled work day. If the employee hire date is between the 1st and the 10th of the month, they are eligible for and will be effective on the plan if enrolled on the first of the month following their hire date. If their hire date is between the 11th and the 31st of the month they are eligible for and will be effective on the plan if enrolled on the first day of the 2nd month following their hire date.

When Your Coverage Ends

Your coverage ends on the last day of the month your active full-time service ends for any reason. Such reasons include death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. And it ends when this plan is changed so that benefits for the class of employees to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this book carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

Dependent Coverage

Eligible Dependents for Dependent Dental Benefits

Eligibility for dependents is the same as outlined in your medical coverage. Even though you do not have to take the medical coverage to receive dental benefits, the eligibility for dependents is the same.

Dependents Not Eligible

We exclude any dependent who is insured by this plan as an employee.

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan , the date your dependent coverage starts depends on when you elect to enroll your initial dependents and agree to make any required payments.

If you do this on or before your eligibility date, the dependent's coverage is scheduled to start on the later of your eligibility date and the date you become insured for employee coverage.

If you do this within the enrollment period, the coverage is scheduled to start on the date you become insured for employee coverage.

Once you have dependent coverage for your initial dependents, you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the newly acquired dependent becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible.

Exception

If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth if: (a) you are already covered for dependent child coverage when the child is born; and (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born.

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your coverage ends.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee's class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at the end of the month that the child attains this coverage's age limit, or otherwise loses eligibility for this plan. It happens to a spouse when a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

Special Enrollment Period

Once each year, during the group enrollment period from November 1st to November 30th , you may elect to enroll in one of the dental expense plan options offered by your employer, or to transfer to another dental expense plan option offered by your employer. Coverage under the new plan option starts on the January 1st that next follows election. You must remain on the Dental Plan which you chose for three (3) years before you are eligible to switch to another Dental Plan option.

Dental Expense Insurance

This insurance will pay many of a covered person's dental expenses. We pay benefits for covered charges incurred by a covered person. What we pay and terms for payment are explained below.

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this plan's List of Covered Dental Services. To be covered by this plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, we mean the charge is the dentist's usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a covered person while he or she is insured by this plan. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for orthodontic treatment is incurred on the date the active orthodontic appliance is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, we'll only

pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends.

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a dental prosthesis, the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

Proof of Claim

So that we may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If we don't receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 12 months of the date of service, we will re-determine the covered person's benefits based on the new information.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the covered person's dentist should send us a treatment plan before he or she starts. This must be done on a form acceptable to Delta Dental. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to us.

A treatment plan should always be sent to us before orthodontic treatment starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this plan. For instance, you may be covered by this plan and a similar plan through your spouse's employer. You may also be covered by this plan and a medical plan. In such instances, we coordinate our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

After This Insurance Ends

We pay benefits for orthodontic treatment to the end of the month in which the covered person's insurance ends.

Special Limitations

Teeth Lost, Extracted or Missing before a Covered Person Becomes Covered by this Plan

A covered person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this plan. We won't pay for a dental prosthesis which replaces such teeth unless the dental prosthesis also replaces one or more eligible natural teeth lost or extracted after the covered person became covered by this plan.

If This Plan Replaces the Prior Plan

This plan may be replacing the prior plan you had with another insurer. If a covered person was insured by the prior plan and is covered by this plan on its effective date, the following provisions apply to such covered person.

- Teeth Extracted While Insured by the Prior Plan
  The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a covered person's dental prosthesis which replaces teeth: (a) that were extracted while the covered person was insured by the prior plan; and (b) for which extraction benefits were paid by the prior plan.
- Orthodontic Payment Limit Credit
  We reduce a covered person's orthodontic payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan's payment limits.

Exclusions That We Will Not Pay For:

- ☐ Any service or supply which is not specifically listed in this plan's List of Covered Dental Services;
- ☐ Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan;

- ☐ Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction;
- ☐ Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments;
- ☐ Overdentures and related services, including root canal therapy on teeth supporting an overdenture;
- ☐ Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons;
- ☐ The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this plan. The use of general anesthesia as an exclusion does not pertain to children with "special needs";
- ☐ The use of local anesthetic;
- ☐ Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment;
- ☐ Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis;
- ☐ Prescription medication;
- ☐ Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges;
- ☐ Pulp vitality tests or caries susceptibility tests;
- ☐ Bite registration or bite analysis;
- ☐ Gingival curettage;
- ☐ The localized delivery of chemotherapeutic agents;
- ☐ Tooth transplants;
- ☐ Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation;
- ☐ Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan;
- ☐ Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant. Exclusions are listed below, but this is not an exhaustive list, so you will want to request a Pre-Treatment Estimate (dental codes listed in parentheses):
    - Second stage implant surgery (D6011);
    - Surgical placements of interim implant body for transitional prosthesis: endosteal implant (D6012);
    - Surgical placement: eposteal implant (D6040);
    - Surgical placement: transosteal implant (D6050);

- Interim abutment (D6051);
- Semi-precision attachment abutment (D6052);
- Bone graft for repair of periimplant defect – does not include flap entry and closure; Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately (D6103);
- Bone graft at time of implant placement (D6104);

- ☐ Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a dental prosthesis; (2) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty;
- ☐ Replacing an existing appliance or dental prosthesis with a like or un-like appliance or dental prosthesis; unless (1) it is at least 10 years old for fixed bridges and labial veneers, at least 5 years old for crowns, inlay and onlays and full or partial dentures and is no longer usable; or (2) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable;
- ☐ A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth;
- ☐ The replacement of extracted or missing third molars/wisdom teeth;
- ☐ Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth;
- ☐ Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis;
- ☐ Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature;
- ☐ Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ);
- ☐ Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws;
- ☐ Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body;
- ☐ Evaluations and consultations for non-covered services; detailed and extensive oral evaluations;
- ☐ The repair of an orthodontic appliance;
- ☐ The replacement of a lost or broken orthodontic retainer.
- ☐ Orthodontic services for anyone above the age of 19.

List of Covered Dental Services

The services covered by this plan are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis and Fluorides

Prophylaxis: Limited to 2 prophylaxis in any 12 consecutive month period.

Fluorides: Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- ☐ Adult prophylaxis covered age 12 and older.
- ☐ Fluoride treatment, topical application - limited to covered persons under age 20 and limited to 2 treatment(s) in any 12 consecutive month period.

Office Visits, Evaluations and Examinations

Office visits, oral evaluations, examinations, limited oral evaluation - problem focused or limited problem focused re-evaluations - limited to a total of 2 in any 12 consecutive month period.

Radiographs

Allowance includes evaluation and diagnosis:

- ☐ Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period;
- ☐ Full mouth series, of at least 14 films including bitewings;
- ☐ Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- ☐ Bitewing films - limited to either a series of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in a calendar year;
- ☐ Intraoral periapical or occlusal films - single films.

Dental Sealants

Permanent 1st and 2nd molar teeth only - Topical application of sealants is limited to the 1st and 2nd permanent molar teeth of covered persons under age 20 and limited to one treatment, per tooth, in any 36 consecutive month period.

Diagnostic Services

Bacteriologic cultures.

Group II - Basic Dental Services (Non-Orthodontic)

Diagnostic Services

Allowance includes examination and diagnosis:

- ☐ Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each covered dental specialty in any 12

consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

- ☐ After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Covered only when no other treatment, other than radiographs and exam, is performed during the same visit.
- ☐ Diagnostic Services: Allowance includes examination and diagnosis:
  - Diagnostic casts - limited to once in a 24 consecutive month period.
  - Histopathologic examinations when performed in conjunction with a tooth related biopsy.
  - Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 30 and older.

Restorative Services

Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the covered person is under age 19, and 36 months if the covered person is age 19 and older. Also see the "Major Restorative Services" section.

- ☐ Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.
- ☐ Resin restorations - limited to anterior teeth only. Coverage for resins on posterior teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.
- ☐ Silicate cement, per restoration.
- ☐ Composite resin.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

- ☐ Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime;
- ☐ Pulp capping, direct;
- ☐ Pulp capping, indirect - includes sedative filling;
- ☐ Vital pulpotomy, only when root canal therapy is not the definitive treatment;
- ☐ Gross pulpal debridement;
- ☐ Pulpal therapy, limited to primary teeth only;
- ☐ Root Canal Treatment:
  - Root canal therapy;
  - Root canal retreatment, limited to once per tooth, per lifetime;
  - Treatment of root canal obstruction, no-surgical access;
  - Incomplete endodontic therapy, inoperable or fractured tooth;
  - Internal root repair of perforation defects.
- ☐ Other Endodontic Services:

- Apexification, limited to a maximum of three visits;
- Apicoectomy, limited to once per root, per lifetime;
- Root amputation, limited to once per root, per lifetime;
- Retrograde filling, limited to once per root, per lifetime;
- Hemisection, including any root removal, once per tooth.

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

- ☐ Periodontal maintenance procedure - limited to a total of two periodontal maintenance procedures in any 12 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).
- ☐ Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.
- ☐ Full mouth debridement - limited to once in any 36 consecutive month period.
- ☐ Provisional splinting.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

- ☐ The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months:
  - Gingivectomy, per tooth (less than 3 teeth);
  - Crown lengthening - hard tissue.
- ☐ The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months:
  - Gingivectomy or gingivoplasty, per quadrant;
  - Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant;
  - Gingival flap procedure, including scaling and root planing, per quadrant;
  - Distal or proximal wedge, not in conjunction with osseous surgery;
  - Surgical revision procedure, per tooth.
- ☐ The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months:
  - Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.
- ☐ The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime:

        - Guided tissue regeneration, resorbable barrier or nonresorbable barrier Bone replacement grafts, when the tooth is present.
    - Periodontal surgery related:
        - Limited and complete occlusal adjustment;
        - Occlusal guards limited to one in a 36 consecutive month period.

Space Maintainers

Limited to covered persons under age 20 and limited to initial appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime:

- Fixed – unilateral;
- Fixed – bilateral;
- Removable – bilateral;
- Removable – unilateral;
- Recementation of space maintainer performed more than 12 months after the initial insertion.

Fixed and Removable Appliances

To Inhibit Thumbsucking - limited to covered persons under age 14 and limited to initial appliance only. Allowance includes all adjustments in the first 6 months after insertion.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care:

- Uncomplicated extraction, one or more teeth;
- Root removal non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan:

- Surgical removal of erupted teeth, involving tissue flap and bone removal;
- Surgical removal of residual tooth roots;
- Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan:

- Alveoloplasty, per quadrant;
- Removal of exostosis, per site;
- Incision and drainage of abscess;
- Frenulectomy, Frenectomy, Frenotomy;
- Biopsy and examination of tooth related oral tissue;
- Surgical exposure of impacted or unerupted tooth to aid eruption;
- Excision of tooth related tumors, cysts and neoplasms;

- ☐ Excision or destruction of tooth related lesion(s);
- ☐ Excision of hyperplastic tissue;
- ☐ Excision of pericoronal gingiva, per tooth;
- ☐ Oroantral fistula closure;
- ☐ Sialolithotomy;
- ☐ Sialodochoplasty;
- ☐ Closure of salivary fistula;
- ☐ Excision of salivary gland;
- ☐ Maxillary sinusotomy for removal of tooth fragment or foreign body;
- ☐ Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this plan.

- ☐ Injectable antibiotics needed solely for treatment of a dental condition;
- ☐ Desensitizing medicaments.

Group III - Major Dental Services (Non-Orthodontic)

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

- ☐ Single Crowns:
  - ■ Resin with metal;
  - ■ Porcelain;
  - ■ Porcelain with metal;
  - ■ Full cast metal (other than stainless steel);
  - ■ 3/4 cast metal crowns;
  - ■ 3/4 porcelain crowns.
- ☐ Stainless steel crowns;
- ☐ Prefabricated resin crowns;
- ☐ Inlays;
- ☐ Onlays, including inlay;
- ☐ Labial veneers;
- ☐ Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure:
  - ■ Cast post and core in addition to a unit of crown or bridge, per tooth;

    - Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth;
    - Crown or core buildup, including pins.
  - ☐ Pin retention, per tooth, limited to two pins per tooth. Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material. Protective restoration, per tooth, covered as a separate benefit only if no other service, other than radiographs and exam, is performed during the same visit;
  - ☐ Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic:
    - Abutment supported crown;
    - Implant supported crown;
    - Abutment supported retainer for fixed partial denture;
    - Implant supported retainer for fixed partial denture;
    - Implant/abutment supported fixed denture for completely edentulous arch;
    - Implant/abutment supported fixed denture for partially edentulous arch.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

  - ☐ Fixed bridges - Each abutment and each pontic makes up a unit in a bridge:
    - Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services";
    - Bridge Pontics;
    - Resin with metal:
      - Porcelain;
      - Porcelain with metal;
      - Full cast metal.
  - ☐ Dentures - Allowance includes all adjustments and repairs done by the dentist furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent appliance:
    - Complete or Immediate dentures, upper or lower;
    - Partial dentures - Allowance includes base, clasps, rests and teeth:
      - Upper, resin base, including any conventional clasps, rests and teeth.
    - Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth;
    - Lower, resin base, including any conventional clasps, rests and teeth;
    - Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth;
    - Interim partial denture (stayplate), upper or lower, covered on anterior teeth only;
    - Removable unilateral partial, one piece cast metal, including clasps and teeth.
  - ☐ Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

- ☐ Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.
- ☐ Recementation, limited to recementations performed more than 12 months after the initial insertion.
  - Inlay or onlay;
  - Crown;
  - Bridge.
- ☐ Adding teeth to partial dentures to replace extracted natural teeth.
- ☐ Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved. Limited to repairs done more than 12 consecutive months after the insertion of the denture.
  - Denture repairs, metal;
  - Denture repairs, acrylic;
  - Denture repair, no teeth damaged;
  - Denture repair, replace one or more broken teeth;
  - Replacing one or more broken teeth, no other damage.
- ☐ Denture rebase, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.
- ☐ Denture reline, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture relines done within 6 months are considered to be part of the denture placement when the reline is done by the dentist who furnished the denture. Limited to reline done more than 6 consecutive months after a denture rebase or the insertion of the denture.
- ☐ Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the dentist who furnished the denture. Limited to adjustments that are done more than 12 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.
- ☐ Tissue conditioning - Tissue conditioning done within 6 months is considered to be part of the denture placement when the tissue conditioning is done by the dentist who furnished the denture.

Group IV - Orthodontic Services (only for members who are 19 years or younger)

Any covered Group I, II or III service in connection with orthodontic treatment.

- ☐ Transseptal fiberotomy.
- ☐ Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- ☐ Treatment plan and records, including initial, interim and final records.
- ☐ Limited orthodontic treatment, Interceptive orthodontic treatment or Comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.

- ☐ Orthodontic retention, including any and all necessary fixed and removable appliances and related visits - limited to initial appliance(s) only.

Network Access

The dental PPO is made up of preferred providers in a covered person's geographic area with whom Delta Dental has contracted and who may provide services at a discount. What we pay is subject to all the terms and conditions of the plan. You can obtain a listing of preferred providers by going to www.consumertoolkit.com.

Coordination of Benefits

Purpose

When a covered person has dental coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense

This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is not an allowable expense. Examples of other expenses or services that are not allowable expenses are:

1. The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is not an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
2. If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is not an allowable expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is not an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.

Claim

This term means a request that benefits of a plan be provided or paid.

Claim Determination Period

This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Closed Panel Plan

This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides

health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination of Benefits

This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent

This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan

This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group coverage, whether insured or uninsured; (3) group-type contracts; (4) medical benefits under group or individual automobile contracts; and (5) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan

This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan

This term means a plan that is not a primary plan.

This Plan

This term means the group health benefits provided under this group plan.

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

This Plan **always** pays secondary to any motor vehicle policy available to a covered person, including any medpay, PIP, No Fault or any plan or program which is required by law. All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
2. If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms,

that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3. In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active or Inactive Employee

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage

The plan that covered the person longer is primary.

Other

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan is Primary

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan is Secondary

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Closed Panel Plans

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person

uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like

considered about your Claim. A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim.

Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately. Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination. To request a formal review of your Claim, send your request in writing to:

Dental Director Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Enrollee's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination. The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

Subrogation and Right of Recovery

Important Notice

This section applies to any health care or loss of earnings benefits under this plan.

Purpose

When a covered person has the right to recover amounts paid by this plan for health care or loss of earnings benefits, this plan also has certain rights. These are explained below.

Definitions

As used in this section, the terms listed below have the meanings shown below:

Covered Person:

This term means any employee or dependent on whose behalf this plan pays health care or loss of earnings benefits. It includes the parent or guardian of any such covered employee or dependent who is a minor or incompetent.

Health Care:

This term means any: (a) major medical; (b) prescription drug; (c) dental; or (d) vision benefits.

Insurance Coverage:

This term means any insurance which provides coverage for: (a) medical expense payments; or (b) liability. This includes, but is not limited to: (i) uninsured motorist coverage; (ii) underinsured motorist coverage; (iii) personal umbrella coverage; (iv)

medical payments coverage; (v) workers compensation coverage; (vi) no-fault automobile insurance coverage; or (vii) any first party insurance.

Third Party:

This term means any party actually, possibly, or potentially responsible for making any payment to a covered person due to the covered person's injury, sickness or condition. This term also means such party's: (a) the liability insurer; or (b) any insurance coverage. But, this term does not mean: (i) this plan; or (ii) the covered person.

Subrogation

When this plan pays a benefit, it will immediately be subrogated to the covered person's rights of recovery from any third party to the full extent of benefits paid.

Recovery

If a covered person receives a payment from any third party or insurance coverage due to an injury, sickness or condition, this plan has the right to recover from, and be repaid by, the covered person for all amounts this plan has paid and will pay due to that injury, sickness or condition, from such payment, up to and including the full amount he or she receives from any third party or insurance coverage.

Constructive Trust

The covered person must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to his or her injury, sickness or condition. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. If the covered person fails to hold such funds in trust, it will be deemed a breach of his or her fiduciary duty to the plan.

Lien Rights

This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.

First Priority Claim

This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not

required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.

Applicable to all Settlements and Judgments

This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgment received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgments, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.

Cooperation

The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.

The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

The plan or its representative has the right to conduct an investigation regarding the injury, sickness or condition to identify any third party. The plan reserves the right to notify the third party and his or her agents of this plan's lien. Agents include, but are not limited to: (a) insurance companies; and (b) attorneys.

Interpretation

In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

Jurisdiction

Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as the plan may choose. The covered person must submit to each such jurisdiction and waive whatever rights may correspond to him or her by reason of his or her present or future domicile.

Glossary

This Glossary defines certain terms appearing in your book.

Active Orthodontic means an appliance, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

Appliance means any dental device other than a dental prosthesis.

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist dentist or a general dentist: restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

Covered Family means an employee and those of his or her dependents who are covered by this plan.

Covered Person means an employee or any of his or her covered dependents.

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this plan.

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan.

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

Employer means WAYNE COUNTY.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

Initial Dependents means those eligible dependents you have at the time you first become eligible for employee coverage. If at this time you do not have any eligible dependents, but you later acquire them, the first eligible dependents you acquire are your initial dependents.

Injury means all damage to a covered person's mouth due to an accident which occurred while he or she is covered by this plan, and all complications arising from that damage. But the term injury does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

Newly Acquired Dependent means an eligible dependent you acquire after you already have coverage in force for initial dependents.

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

Payment Limit means the maximum amount this plan pays for covered services during either a benefit year or a covered person's lifetime, as applicable.

Payment Rate means the percentage rate that this plan pays for covered services.

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

Plan means the Delta Dental group dental plan purchased by the planholder.

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this plan. To be considered a prior plan, this plan must start immediately after the prior coverage ends.

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

We, Us, Our and Delta Dental mean The Delta Dental Insurance Company.

Delta Dental's Responsibilities

The dental expense benefits provided by this plan are funded solely by the employer. The benefits are not guaranteed by a policy of insurance issued by Delta Dental. Delta Dental does supply administrative services, such as claims services, including the payment of claims, preparation of employee benefit books, and changes to such benefit books.

Delta Dental is located at 5600 Blazer Parkway, Suite 150, Dublin, OH 43017.

Termination of This Group Plan

Your employer may terminate this group plan at any time.

When this plan ends, you may be eligible to continue your coverage. Your rights, if any, upon termination of the plan are explained in this benefit book.

Forms

The following pages contain frequently used forms for your convenience!

Forms not contained in this section can be found at:
www.consumertoolkit.com

Please photocopy all forms, keeping the originals in your binder, so that you can continue to use in future years.

DELTA DENTAL

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PRE-TREATMENT ESTIMATE

MAIL CLAIMS TO DELTA DENTAL
PO BOX 9085
FARMINGTON HILLS, MI 48333-9085

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE? ☐ NO IF NO, SKIP TO #11 ☐ YES
3. AMOUNT OF PRIMARY PAYMENT $
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP
5. DATE OF BIRTH
6. GENDER ☐ M ☐ F
7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)
8. PLAN/GROUP NUMBER
9. RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP
12. DATE OF BIRTH
13. GENDER M F
14. SUBSCRIBER ID (SSN OR ID#)
15. PLAN/GROUP NUMBER
16. EMPLOYER NAME

PATIENT INFORMATION

17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)
18. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
19. DATE OF BIRTH
20. GENDER ☐ M ☐ F
21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS ☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH	PERMANENT																PRIMARY										29. TOTAL FEE CHARGED
30. PLACE X ON MISSING TOOTH NUMBERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

REMARKS

31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT ☐ DENTAL OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER
35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____
36. IS TREATMENT RELATED TO ORTHODONTICS? ☐ NO ☐ YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____
37. TREATMENT RESULTING FROM: ☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT
38. REPLACEMENT OF PROSTHESIS? ☐ YES DATE PRIOR PLACEMENT _____ ☐ NO

BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP
40. NPI
41. LICENSE NUMBER
42. TIN
43. PHONE NUMBER ( )

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT.

X
SIGNED (TREATING DENTIST) DATE

45. NPI
46. LICENSE NUMBER
47. TIN
48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)
49. PHONE NUMBER ( )
50. ADDITIONAL DENTIST ID
51. SPECIALTY CODE

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For the fastest processing, submit claims electronically through our **Dental Office Toolkit**!
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- **Clearly type, hand write, or use a computer printer to enter information.**
- **Use all upper-case (capital) letters, if possible.**
- **Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.**
- **Keep information within the correct field.**
- **Make sure the typewriter or printer ribbon is dark and the print can be easily read.**
- **Cover mistakes with line tape and print or type over—do not use liquid correction fluid.**
- **Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.**

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- **If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter $0 unless the primary carrier's determination of payment was $0. DO NOT ATTACH the primary carrier's voucher.**
- **Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.**

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- **Hand or machine print**
- **When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).**
- **Use current ADA CDT procedure codes.**
- **Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.**

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- **The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.**
- **Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.**
- **Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.**

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 9089 Farmington Hills, MI 48333-9089	800-524-0149

Delta Dental of Michigan
www.deltadentalmi.com

Delta Dental of Ohio
www.deltadentaloh.com

Delta Dental of Indiana
www.deltadentalin.com

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www.deltadentalnc.com

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