Delta Dental Website

Member Portal: www.memberportal.com

Website: www.deltadentaloh.com

You can find helpful information about your Delta Dental benefits plan 24 hours a day, 7 days a week.

Here's What You Will Find on the Member Portal:

- ☐ Find A Provider (Quickly and Easily!)
  - Create a customized list of providers based on preferences or look up a specific provider
  - Unique features include ability to create a short list of "favorite" providers for quick reference, plus get maps and directions to an office
  - Get your results printed, emailed or in .pdf format
- ☐ Estimate the Cost of Your Dental Care:
  - View estimates for cost of services prior to receiving the actual treatment
  - Look up coverage amounts, including deductibles and co-insurance amounts
  - View claims activity
- ☐ Print Dental Card and Claim Form:
  - Simply visit the web site listed above and click on "View & Print Member ID Card" or the "Claims" tab.
  - If you arrive at your doctor's appointment and forgot your card, it's no problem as you can simply tell them that Delta Dental is your insurance carrier and they will take care of it for you!
- ☐ Read About Oral Health
  - Click on the "Help" tab, then click "Health and Wellness" to learn about important health tips regarding oral cancer, fluoride, beverage choices, dental implants, tongue piercing and overall oral health!

How To Register For The First Time:

1. Go to **www.memberportal.com**
2. Click on "Sign Up!"
3. Follow the easy instructions!

How To Find a Provider:

1. Go To **www.deltadentaloh.com**
2. Click on "Find a Dentist"
3. Find *Delta Dental PPO and Delta Dental Premier* and click on "Search"
4. Choose the specialty you are searching for in the first dropdown list.
5. Choose either Delta Dental PPO or Delta Dental Premier. Both of these are in-network. However, Delta Dental Premier will pay a higher percentage towards your claim.
6. Click "Find Dentists"
7. *You may also customize your search by name, city, zip code or distance.*
8. Once you receive your results, you may print, email or .pdf your results. If you want to print, email or .pdf the results of only a few select dentists, simply check the box "Add to my list" next to each dentist, then click on "My List" at the top of the screen (right-hand side) and choose either print, email or .pdf.

Things To Remember:

- ☐ It is strongly recommended that you obtain a pre-treatment estimate for any major medical service. Please ask your doctor to submit this request to Delta Dental. Pre-treatment estimates come directly from Delta Dental; they do not come from your dentist. Also refer to your Summary Plan Description at the back of this tab.
- ☐ If you are pregnant or have diabetes or heart disease, talk with your doctor about getting two additional cleanings.
- ☐ Medical and Dental Health go hand-in-hand

Most people tend to think of their dental health as being completely separate from their general medical well-being. However, in many instances, this is not the case. Oral hygiene —or the lack thereof — can affect a person's medical health. Similarly, a person's medical health can affect his dental welfare. Medical and dental issues are not separate entities.

Updated 10/7/2022

Special Conditions

There are some conditions that can complicate a person's oral health. They can either aggravate dental conditions or they can alter how dental problems are treated and managed. Here are some medical issues that affect dental health. **If you have any of these conditions, please be sure to talk to both your healthcare provider and your dentist**.

Cardiovascular Disease

Gum disease, particularly periodontitis, can affect cardiovascular disease. Although more research needs to be done, some scientists are saying that gum disease can be a cause of heart disease, strokes, clogged arteries and bacterial endocarditis.

Sure, it sounds strange; however, gum disease certainly does spread past a person's mouth. The bacterium from the periodontitis enters a person's bloodstream and can travel to the heart. In this case, the medical problem certainly may be caused by the dental problem.

Osteoporosis

Bone loss from this disease often shows up first in the mouth—dentists are sometimes the first ones to spot it, recommending that patients speak with their medical doctors about possibly having osteoporosis.

If this disease is not managed, the bone loss can worsen from year to year. This can cause problems with the teeth, eventually causing them to fall out.

Diabetes

Not taking care of the teeth—in other words, having poor oral hygiene—can make managing diabetes a difficult prospect. Gum disease infections can cause a person's blood sugar levels to spike, therefore needing larger doses of insulin to keep under control.

What's more, having diabetes makes a person more susceptible to getting gum disease in the first place. So, it is even more essential for people with diabetes to practice excellent dental hygiene habits.

Diabetes also increases the likelihood of a person having dry mouth, cavities and tooth loss. With this condition, the medical and dental problems go hand in hand.

Cancer

Chemotherapy treatments for any type of cancer can cause dental issues, such as dry mouth and gum disease.

Moreover, if a person is receiving radiation in the head or neck area, he may develop lesions in the mouth, very sensitive teeth and rapid tooth decay.

Pregnancy/Birth

Obviously, pregnancy and birth are not diseases. However, gum disease can have a profound effect on pregnancy and birth.

Much like the bacteria from periodontitis can spread from the gums to the heart via the bloodstream, it can also spread through the bloodstream to the placenta in the womb or into the amniotic fluid. This can cause premature birth. Babies who are born too early may not have had a chance to fully develop and may end up with life-threatening problems.

HIV/AIDS

Indications of this medical problem often show up in the mouth first through a serious dental infection. People may also develop white spots or strange lesions in the mouth if the gum disease is left untreated.

Rather than thinking of medical health or dental health separately, people should instead think of body health.

You May Be Eligible for Additional Cleanings

If you have been diagnosed with any of the following conditions, you are eligible for 2 additional cleanings (which is a total of 4) each year:

- Pregnancy with periodontal disease
- Diabetic with periodontal disease
- Renal Failure/Dialysis
- Head and Neck Radiation
- Infective Endocarditis
- Suppressed Immune System
    - Chemotherapy/Radiation
    - HIV Positive
    - Organ Transplant
    - Stem Cell (Bone Marrow) Transplant

Enhanced Benefits for Vulnerable Population

In order to make oral health benefits more accessible and less overwhelming, we offer enhanced dental benefits for members with qualifying special health care needs.

These enhanced benefits include:

- Additional visits to the dentist's office and/or first treatment consultations prior to appointment
- Up to four total dental cleanings in a benefit year (see above).
- Treatment delivery modifications
- The use of anesthesia if necessary

Coverage At A Glance

The following is a snapshot of the Wayne County Dental Plan Design. For further details and description, please refer to the Summary Plan Description (SPD) at the back of this section.

Dental Plan Design

IMPORTANT! Remember to request a <u>Pre-Treatment Estimate</u> if you are having dental work which may cost $300 or more! Please ask your doctor to submit this request to Delta Dental.

TYPE OF SERVICE	Traditional Plan	Orthodontic Plan
Annual Deductible	$25 per person	$25 per person
Maximum Per Person Benefit		
Non-Orthodontics	$2,000 per year	$2,000 per year
Orthodontics	$500 Lifetime	$2,000 Lifetime
Orthodontic Eligibility Requirement	Up to Age 19	Up to Age 19
Preventive and Diagnostic Dental Service	100%	100%
Not calculated towards annual maximum benefit		
Periodic Oral Examinations		
Twice per calendar year		
Bitewing X-Rays - 1 Series per calendar year		
Dental Prophylaxis (Cleanings)		
Twice per calendar year		
Fluoride Treatments		
Twice per calendar year under age 16		
Palliative Treatment (Relief of Pain)		
Covered only if no other services provided		
Sealants Under Age 16 and once per tooth Every 3 Years		
Once per first or second permanent molars		

TYPE OF SERVICE	Traditional Plan	Orthodontic Plan
Basic Dental Services - Subject to Deductible	80%	80%
Complete Series or Panorex X-rays		
Limited to One Time Per 36 Months		
Fillings: Includes Amalgam and Composite/white fillings		
Occlusal Guards – 1 per 5-year period		
Root Canal Treatment		
Root Planing - 1 Time Per Quadrant Per 24 Months		
Periodontal Surgery - Once In Any 36 Month Period		
Simple Extraction		
Surgical Extraction including Impacted Wisdom Teeth		
Repairs to Full or Partial Dentures or Bridges		
Limited to repairs or adjustments done within 12 months after the initial insertion		
Major Dental Services - Subject to Deductible*	80%	50%
Crowns - One Time Per Tooth Every 5 Years		
Only When A Filling Cannot Restore The Tooth		
Fixed Bridges - One Time Per Tooth Every 5 Years		
Only When A Filling Cannot Restore The Tooth		
Full Dentures - Once Every 60 Months		
Implants – please read your SPD for more details as most implants are covered; however, some services related to the implant are not (make sure to request a Pre-Treatment Estimate!)		
Inlays And Onlays - One Time Per 5 Years		
Only When A Filling Cannot Restore The Tooth		
Partial Dentures - Once Every 60 Months; No Allowances		
For Precision or Semi-Precision Attachments		
Re-Cement Bridges, Crowns, Inlays - Once Every 6 Months		
Relining Dentures - Limited To 1 Time Per Year		
Orthodontic Services.....	50% up to $500	50% up to $2,000
Diagnose or Correct Misalignment of the Teeth or Bite		
Including Phase 1 and Phase 2 -		
This is a short recap of your dental benefits. Please see the Summary Plan Description for additional details and terms of your actual coverage.		

*** ***PLEASE NOTE that if you choose to go out-of-network, you may be responsible for the difference between the contracted amount and the cost of service, in addition to any coinsurance/copays.***

Summary Plan Description

Wayne County Dental Benefit Plan

Table of Contents

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

Elected Officials/Employees

To be covered by this plan, the following requirements must be met:

- ☐ You must be *actively employed* (defined as actively working, using any form of paid leave, or on approved FMLA); and
- ☐ You will need to be in an eligible class, as defined below; and
- ☐ You will need to meet the Eligibility Date criteria described below.
- ☐ You will need to enroll and be accepted for coverage

Determining if You Are in an Eligible Class

You are in an eligible class if:

- ☐ You are an Elected Official or regular full-time employee, as defined by your employer (for purposes of this SPD, full-time is defined as being expected or determined to be a permanent employee working on average 30 or more hours per week).
- ☐ You do not meet the regulations above, but you meet the regulations to be eligible for insurance under Affordable Care Act (ACA) rules.

Determining When You Become Eligible

You become eligible for the plan on your Eligibility Date, which is determined as follows:

On the Plan Coverage Start Date

If you are in an eligible class and are currently enrolled on the plan coverage start date, then your coverage Eligibility Date is the same as the plan coverage start date and there is no

waiting period.

After the Plan Coverage Start Date

If you are hired or enter an eligible class after the plan coverage start date, your Eligibility Date is the first of the month that occurs 1 calendar month *after* the month in which you are hired (this is considered your Administrative Period).

When Your Coverage Begins

If you met the qualifications of an eligible class and completed all requirements for enrollment within the defined time, and you are accepted on the Plan, then your insurance will start as follows:

- ☐ On your Eligibility Date if you enroll as a new employee; or
- ☐ On the first day of the following calendar year if you enroll during Open Enrollment; or
- ☐ On the date of a Life Event if you enroll due to a qualifying Life Event; and

When Your Coverage Ends

Coverage under this Plan always ends on the last day of the month. Your health benefits coverage will end on the last day of the month in which the following occurs if:

- ☐ The health benefits plan is discontinued;
- ☐ You voluntarily stop your coverage;
- ☐ You are no longer eligible for coverage;
- ☐ You do not make any required contributions;
- ☐ You become covered under another plan offered by your employer;
- ☐ Your employer notifies Delta that your employment is ended;
- ☐ Your employment is terminated by your own choice;

If a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.

It is your employer's responsibility to let Delta know when your employment ends.

Inactive Pay Status

An employee who is not in an active pay status (vacation, comp/flex time, sick, paid/unpaid Family Medical Leave) is considered to be Inactive Pay Status and not eligible to be on the Plan. Please note that Workers' Comp is not considered active pay status.

- ☐ Please keep in mind that unpaid time off does not constitute active pay status for purposes of the Plan At the point that they are **not** in an active pay status, their insurance eligibility is over and they are terminated from the Plan on the last day of the month in which they were active. (for instance, an employee who is terminated from the Plan on May 9 would Stay on the Plan through May 31);
- ☐ Employees who return to active pay status within 60 calendar days of the date they are terminated from the Plan (using May 31 from the above example) will be able to start back on the Plan effective on the date they return to active pay status. They will not have to wait to join the Health Plan like a new employee;
- ☐ Employees who return to active pay status 61 or more calendar days from the date they are terminated from the Plan will be treated as a new employee for purposes of their Effective

Date on the Plan;

- ☐ Employees who elect COBRA and are on COBRA on the date of their return to active pay status will start on the Plan effective on the date of their return, no matter if their return is over or under 60 days. These employees never left the Plan, so they do not have to wait like a new employee.

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

Dependent Coverage

Obtaining Coverage for Dependents

Qualified dependents can be covered under this Plan. You may enroll the following dependents:

- ☐ Your Spouse.
- ☐ Your children.

Delta will rely upon the Plan Administrator to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Spouses

To be eligible, a Spouse must meet the following definition:

- The marriage is recognized by the State of Ohio as being a legal marriage; and
- You are married and living together as a married couple; or
- You are married and living apart, but not legally separated under a decree of divorce, separate maintenance or legal separation document; or
- You are separated under an interlocutory (not final) decree of divorce.

Married employees cannot be members on separate county insurance plans (unless one of the employees is employed by a noncounty agency that does not allow Spouses on their plan).

Coverage for Eligible Children

To be eligible, a child must be under 26 years of age and qualify as identified below under "An Eligible Child".

An Eligible Child includes:

- Your biological children;
- Your Stepchildren, as long as their parent is included on the insurance plan as a Spouse;
- Your legally adopted children or children placed with you for adoption;
- Any children for whom you (our employee) are responsible under court order.

Coverage for a handicapped child may be continued past the age limits shown above. See "Handicapped Dependent Children" for more information.

Important Notice: In the case of Stepchildren, whether or not the custodial parent is a member on the plan, they should have access to their covered child's medical card with the

ability to communicate that information to the child's doctor.

Important Reminder: Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Please note that you will need to provide proof of your dependent(s)' eligibility (such as a Marriage or Birth Certificate and any court orders) when you originally enroll your dependent(s) and whenever an eligibility audit is conducted.

Handicapped Children

Dental Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- ☐ he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- ☐ he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Delta no later than 31 days after the date your child reaches the maximum age under your plan.
Coverage will cease on the first to occur of:

- ☐ Cessation of the handicap.
- ☐ Failure to give proof that the handicap continues.
- ☐ Failure to have any required exam.
- ☐ Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Delta will have the right to require proof of the continuation of the handicap. Delta also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

When Dependent Coverage Begins

If you they met the requirements for an eligible spouse or child, and you are either already insured for employee coverage or will enroll for employee and dependent coverage at the same time, and you completed all requirement for enrollment within the defined time, and your dependent(s) are accepted on the Plan, then dependent coverage will start as follows:

- ☐ On your Eligibility Date if you enroll as a new employee with dependents on a family plan; or
- ☐ On the first day of the following calendar year if you enroll them during Open Enrollment; or
- ☐ On the date of a Life Event if you enroll them due to a qualifying Life Event.

When Dependent Coverage Ends

Coverage under this Plan always ends on the last day of the month. Coverage for dependent(s) will end on the last day of the month in which any of the following events occur.

Coverage for your dependents will end if:

- ☐ You are no longer eligible for dependents' coverage;
- ☐ You do not make the required contribution toward the cost of dependents' coverage;
- ☐ Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees;
- ☐ Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent (examples: divorce, child over 26 years of age, etc.); or
- ☐ You remove the dependent from your plan for any reason during a qualifying Life Event enrollment or an Annual/Open Enrollment.
- ☐ As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- ☐ *PLEASE NOTE that failure to notify Wayne County of a dependent termination, due to not meeting the plan's definition of a dependent, will result in the employee being responsible for 100 percent of any and all claims paid for that dependent after the date which they should have been terminated.*

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.

How and When to Enroll

At any enrollment opportunity, you may elect to enroll in one of the dental plan options offered by your employer, or to transfer to another dental plan option offered by your employer; however, 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.

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by the Plan Administrator. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your Eligibility Date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify for a Life Event enrollment, as described below.

Late Enrollment

If you do not enroll for coverage when you first become eligible, but wish to do so later, you may

request information from your employer on when and how you can enroll.

Annual Enrollment/Open Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. Annual enrollment typically occurs from mid-October to mid-November. The choices you make during this annual enrollment period will become effective on January 1 of the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Life Events, as described below.

Life Event Enrollment

You are not permitted to terminate, add or make changes to a plan or the dependent(s) on a plan at any time other than Open Enrollment, unless you qualify for a Life Event as defined below. You may make changes to your insurance, including your dependent(s) and/or plan options, for a Life Event if you:

- ☐ Are an Eligible Employee in an Eligible Class at the time of the Life Event; and
- ☐ You, or one of your dependents that are on or will be added to/removed from the plan, experience a qualifying Life Event; and
- ☐ You notify your employer and complete an enrollment within 31 days of the event.

Enrollment instructions will be provided by your employer upon request.

The following will be considered as qualifying Life Events and proof may be required as a condition of eligibility and must be supplied upon request:

- ☐ *Marriage.* This plan will allow for the addition or termination of insurance for a marriage, involving you or your child that will be terminating from your plan, that is recognized by the State of Ohio as being a legal marriage and with submission of a certified marriage certificate.
- ☐ *Divorce, Legal Separation or Annulment.* This plan will allow for the addition or termination of insurance for a divorce, legal separation or annulment involving you or your child that will be joining or terminating from your plan and with submission of an applicable certified court certificate.
- ☐ *Death of Spouse or Child*.
- ☐ *Birth, Adoption, or Placement for Adoption.* New children must fit the definition of an Eligible Child and will require submission of a certified birth certificate unless:
    - ■ Birth by a dependent currently covered on the plan is being used as a reason for that dependent to terminate from the Employee's plan; or
    - ■ A new child is placed in your care for adoption and you have taken on the legal obligation for total or partial support of the child and a certified birth certificate is not available and you are able to provide another acceptable form of proof of placement.
- ☐ *Termination of the Employment of Spouse or Child.*
- ☐ *Start of New Employment of Spouse or Child*
- ☐ *Change in Employment Status (between part-time and full-time) by the Employee, Spouse or Child.*

- ☐ *A Strike or Lockout Reducing Hours of Employment of Employee, Spouse or Child*
- ☐ *Start or Return from Unpaid Leave of Absence from Employment by Employee, Spouse or Child*
- ☐ *Significant Change in Health Coverage of Employee, Spouse or Child*
- ☐ *A Change in the Place of Residence or Work of Employee, Spouse or Child, Which Changes that Individual's Plan Service Area*
- ☐ *Child of Employee Becoming Ineligible for Coverage.* This includes a child becoming ineligible due to age limits.
- ☐ *Entitlement to Medicare or Medicaid of Employee, Spouse or Child*
- ☐ *Issuance of a Judgement, Decree or Order That Requires Health Coverage for Employee's Child.* In the case of dependent care benefits under Article VIII, such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125. Such events will be triggered by the receipt of a National Medical Support Notice (NMSN) that has been issued by a court or a state child support enforcement agency authorized to issue Child Support Orders that provides for the medical support of a child. This plan will provide coverage for a child who is identified on a NMSN, if:
    - The child meets the plan's definition of an eligible dependent; and
    - A state child support enforcement agency issues a NMSN that the group health plan determines to be qualified; and
    - The issuing state child support enforcement agency does not issue a Notice to Employer/Health Plan Administrator of Expiration or Terminations of Withholding Requirements Under the NMSN.

  Coverage for the dependent will become effective on the date of issuance of the medical Child Support Order if received within 31 days of issuance, or as required by the NMSN.
- ☐ *Enrollment of Employee, Spouse or Child in a State or Federal Healthcare Exchange*

Important Notices:

- If you do not report your Life Event and submit all required documentation and your enrollment is not received within 31 days of the date the Life Event took place, then you will not qualify to make changes to your insurance plan and will need to wait to make changes during the next annual enrollment period.
- You must pay any increase in premiums in full or coverage will not be effective.
- For child(ren) under a NMSN, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims may be paid to the custodial parent.
- All current requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) outlined in the Special Enrollment Notice (behind Tab 10) are covered by the Plan.

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.

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

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 provision applys to such covered person.

- 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. This includes Oral and Maxillofacial Treatment unless not covered by your Medical insurance;
- ☐ 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):
    - o Second stage implant surgery (D6011);
    - o Surgical placements of interim implant body for transitional prosthesis: endosteal implant (D6012);
    - o Surgical placement: eposteal implant (D6040);
    - o Surgical placement: transosteal implant (D6050);
    - o Interim abutment (D6051);
    - o Semi-precision attachment abutment (D6052);
    - o 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);
    - o 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.

See Addendum A for a full list of Exclusions and Limitations.

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)

Preventative and diagnostic services are not calculated towards the annual maximum benefit.

Prophylaxis and Fluorides

Prophylaxis: Limited to 2 prophylaxis per calendar year.

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 16 and limited to 2 treatment(s) per calendar year.

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 per calendar year.

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 16 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 - 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 per calendar year. 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 5-year 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.deltadentaloh.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.

Addendum A: Delta Exclusions & Limitations

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, with the exception of congenitally missing teeth.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.

31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration, implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. 3-D scans and images.
43. Myofunctional therapy.
44. Mounted case analyses.
45. Molecular, antigen or antibody testing for a public health related pathogen.
46. Vaccinations.
47. Bone replacement grafts when performed in conjunction with a hemisection.
48. Fabrication, adjustment, reline, or repair of sleep apnea appliances.
49. Removal of non-resorbable barrier.
50. Intraoral tomosynthesis images.
51. Any and all taxes applicable to the services.
52. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Non-Participating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age two or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy

or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as a comprehensive periodontal evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
31. Reline or any adjustment or repair to a sleep apnea appliance within six months of the delivery.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
34. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
35. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
36. Capture only images which are not associated with any interpretation or reporting.
37. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
38. Surgical removal of implant body when performed within three months of an implant/mini-implant on the same tooth by the same dentist or dental office.
39. Non-surgical implant removal when performed within six months of an implant/mini-implant on the same tooth by the same dentist or dental office.
40. Scaling and root planing when performed on the same day as surgical root repair or exposures.
41. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.
42. Intraorifice barriers.
43. Removal of non-resorbable barrier when performed by the same dentist who placed the barrier.
44. Excision of benign or malignant lesions when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.
45. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e., to

the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes (general or periodontal cleanings), full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age eight and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five-year period.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in any five-year period.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36-month period.
17. Prosthodontic Services limitations:
    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    c. A removable unilateral partial denture is payable once per quadrant in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
    e. Rebase hybrid prostheses are payable once in any five-year period per appliance.
    f. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    g. Implant removal is payable once per tooth or area in a five-year period.
    h. Implant maintenance is payable once per any 12-month period.
    i. Removal of a broken implant retaining screw is payable once in a five-year period.
18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
    a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.
    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.
    a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
    f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
23. Maximum Payment: All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
25. Caries risk assessments are payable once in any 12- month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per tooth per lifetime on second permanent molars for Members age 14 and under.
32. One cone beam CT is allowed within a 12-month period except when performed for TMD treatment.
33. Restorations performed within two months of caries arresting medicament.
34. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan.

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three- year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a 12- month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a 12-month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Forms

The following pages contain frequently used forms for your convenience!

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

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