DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

MIAMI-DADE COUNTY PUBLIC SCHOOLS

Primary Enrollee's Name

deltadentalins.com/mdcps

Group No: 17421

Effective Date: January 1, 2020

This Certificate Contains a Deductible Provision

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Attachments

INTRODUCTION

We are pleased to welcome you to the group dental plan for Miami-Dade County Public Schools. Your plan is underwritten and administered by Delta Dental Insurance Company ("Delta Dental"). Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

Using This Evidence of Coverage

This Evidence of Coverage booklet, which includes Attachment A Deductibles, Maximums and Contract Benefit Levels – High Plan (Attachment A), Attachment B Services, Limitations and Exclusions – High Plan (Attachment B), Attachment C Deductibles, Maximums and Contract Benefit Levels – Standard Plan (Attachment C), Attachment C-1 Table of Enrollee Copayments – Standard Plan (Attachment C-1), and Attachment D Services, Limitations and Exclusions – High Plan (Attachment D), discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at deltadentalins.com/mdcps or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 800-693-2589 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance, including the resolution of complaints. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

Anthony S. Barth, President

DEFINITIONS

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Delta Dental will pay for covered dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate.

Contract: the agreement between Delta Dental and the Contractholder, including any attachments.

Contract Benefit Level: the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied as shown in Attachment A for the High Plan and in Attachment C for the Standard Plan Out-of-Network Benefit.

Contractholder: the employer, union or other organization or group as named herein contracting to obtain Benefits.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Deductible: amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

Delta Dental Premier® Provider (Premier Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee: the fee for a Single Procedure covered under the Contract that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO℠ Provider (PPO Provider): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee contracted fees as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee: the fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this booklet's cover.

Eligible Dependent: a dependent of an Eligible Employee eligible for Benefits.

Eligible Employee: any employee or retiree as eligible for Benefits.

Enrollee: an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Enrollee Copayment -- the amount an Enrollee is responsible for paying for a covered service listed in the Table of Enrollee Copayments, which applies to In-Network Benefits in the Standard Plan, prior to receiving treatment from a PPO Provider. The Table of Enrollee Copayments is in Attachment C-1.

Enrollee's Effective Date of Coverage: the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee for a PPO Provider in the same geographic area.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee for a PPO Provider in the same geographic area.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period: the month of the year during which employees may change coverage for the next Contract Year.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Procedure Code: the Current Dental Terminology© (CDT) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee or Eligible Dependent);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent Spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Spouse: a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

Table of Enrollee Copayments -- the list of covered dental services for the Standard Plan's In-Network Benefits showing the copayment amount to be paid by the Enrollee prior to receiving treatment from a PPO Provider for each covered Single Procedure. The Table of Enrollee Copayments is in Attachment C-1.

PREMIUMS

You are required to contribute towards the cost of your coverage.

You are required to contribute towards the cost of your Dependent Enrollee's coverage.

We may cancel the Contract 30 days after written notice to the Contractholder if monthly premiums are not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

The Contractholder is responsible for establishing eligibility for you and your dependents.

Eligible Dependents become eligible on:

- the date the Eligible Employee is eligible for coverage,
- as soon as an Eligible Dependent becomes the dependent of an Eligible Employee or
- at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include Primary Enrollee's Spouse and children as follows:

- from birth to the end of the Calendar Year in which they turn 25 if they are supported by the Primary Enrollee, live in the Primary Enrollee's household or are enrolled as full-time or part-time students in an accredited school;
- grandchildren up to 18 months of age if the parent is a covered dependent; and
- from the beginning of the Calendar Year in which occurs their 26th birthday to the end of the Calendar Year in which they turn 30 if they do not have children of their own, they are Florida residents or full-time or part-time students and they are not provided coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan or is not entitled to benefits under Title XVIII of the Social Security Act.

Children include natural children, stepchildren, foster children, adopted children, children placed for adoption, custodial children, children for which the employee has been appointed legal guardian and newborn children, including a newborn child of a covered dependent child and children of a partner as recognized by the Contractholder. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.

Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children are eligible from the moment of placement in your residence, or in the case of a newborn child, from the moment of birth, if you have entered into a written agreement to adopt the child prior to the birth of the child. Notice of birth, adoption placement, foster home placement or other custodial placement of a child with employee must be received within 31 days of the birth or placement. If notice of birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.

An overage dependent child is eligible if:

- he/she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
- he/she is chiefly dependent on the Eligible Employee for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Enrollment will continue as long as the dependent relies on the Eligible Employee for support because of a physically or mentally disabling injury, illness or condition that began before he/she reached the limiting age.

Dependents on active military duty are not eligible.

Enrollment Requirements

- If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during an Open Enrollment Period. If notice of a birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of a birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- All Eligible Dependents must be enrolled as Dependent Enrollees if dependent coverage is elected.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or a Dependent Enrollee but not both at the same time.

Loss of Eligibility

An Enrollee's coverage is terminated on the date reported by the Contractholder or the day the Contract is terminated.

Continuation of Benefits on Voluntary Loss of Eligibility

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within 90 days of your voluntary termination of coverage.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than an approved leave of absence or as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

Coverage will resume as reported by the Contractholder, provided you submit an enrollment card requesting that coverage be reactivated.

*Coverage for you and your dependents is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act of 1993 does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same Calendar Year, Deductibles and maximums will resume as if you were never gone.

Extension of Benefits

In the case of services provided to you at the termination of the Contract, an Extension of Benefits in the form of reimbursed expenses will apply if:

- the dental services were recommended in writing and commenced while the policy was in effect by the Provider to you while you were covered by the Contract.
- the dental services were for procedures other than routine examinations, prophylaxis, x-rays, sealants or orthodontic services.
- the dental services were performed within 90 days after your coverage ceased under the Contract and the termination of coverage did not occur as a result of your, or, in the case of a dependent child, the child's parent's voluntary termination of coverage.

The extension of Benefits terminates upon the earlier of:

- the 90-day period specified in the above third bullet item; or
- the date you become covered under a succeeding policy

If coverage or services for the dental procedures referred to in the above first bullet item are excluded by the succeeding contract through the use of an elimination period, you are not covered by the succeeding contract and the Extension of Benefits does not terminate.

All contractual Limitations, Exclusions or reductions that would have applied to the specific dental services had the coverage on you not terminated apply during the Extension of Benefits.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B for the High Plan or Attachment D for the Standard Plan. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A for the High Plan and Attachment C for the Standard Plan. If you receive dental services from a Provider outside the state of Florida, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance - High Plan and Out-of-Network Standard Plan

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in Attachment A for the High Plan and Attachment C for Out-of-Network Standard Plan, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

Table of Enrollee Copayments – In-Network Standard Plan

Our provision of Benefits to PPO Providers is limited to the Maximum Contract Allowance less the amount for a covered service shown on the Table of Enrollee Copayments, which is in Attachment C-1. The amounts for covered services are called "Enrollee Copayments." The Enrollee is responsible for paying the Enrollee Copayments prior to receiving any treatment from a PPO Provider. The Contractholder has chosen to require Enrollee Copayments under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Copayment, Delta Dental will be obligated to provide as Benefits only the applicable amount of the Provider's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in Attachment A for the High Plan and Attachment C for the Standard Plan. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Most dental programs have a maximum amount. A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in Attachment A for the High Plan and Attachment C for the Standard Plan. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with an Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which plan is the "primary" program?
  (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
  (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a) secondary to the plan covering the insured person as a dependent and
    b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
  (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
    b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
  (4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal

custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).

(6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);

b) Second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.

(9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. In addition, you and your family members can see different Providers.

Remember, you enjoy the greatest Benefits—including out-of-pocket savings—when you choose a PPO Provider. To take full advantage of your dental plan, we highly recommend you verify a dentist's participation status with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

Locating a Delta Dental PPO Provider

There are two ways in which you can locate a PPO Provider near you:

- You may access information through our website at deltadentalins.com/mdcps. This website includes a Provider search function allowing you to locate PPO Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 800-693-2589 and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — PPO Provider

Payment for covered services performed for you by a PPO Provider is calculated based on the Maximum Contract Allowance. PPO Providers have agreed to accept the Delta Dental PPO Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A for the High Plan and Attachment C for Out-of-Network Standard Plan. Delta Dental's Payment is sent directly to the PPO Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Premier Provider

Payment for covered services performed for you by a Premier Provider is calculated based on the Maximum Contract Allowance. Premier Providers have agreed to accept the Delta Dental Premier Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A for the High Plan and Attachment C for Out-of-Network Standard Plan. Delta Dental's Payment is sent directly to the Premier Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Delta Dental Provider

Payment for services performed for you by a Non-Delta Dental Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A for the High Plan and Attachment C for Out-of-Network Standard Plan. Non-Delta Dental Providers have no agreement with Delta Dental and are free to bill you for any difference between what Delta Dental pays and the Submitted Fee.

When dental services are received from a Non-Delta Dental Provider, Delta Dental's Payment is sent directly to the Primary Enrollee, unless you have assigned the Benefits to the Provider. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A for the High Plan and Attachment C for Out-of-Network Standard Plan. Since our payment for services you receive may be less than the Non-Delta Dental Provider's actual charges, your out-of-pocket cost may be significantly higher. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

Delta Dental does not require special claim forms. However, most dental offices have Claim Forms available. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

CLAIMS APPEAL

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to us at the address shown below:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

We will send you a written acknowledgment within 15 days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send the Enrollee a decision within 30 days after receipt of the Enrollee's appeal or grievance.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed (paid or denied):

- within 45 days after receipt of due written proof of such loss. If additional information is requested to process the claim, we will notify you and your Provider within 45 days of written proof of loss; and
- within 60 days after the requested information is received for any disputed portion of the claim.

Claims not processed (paid or denied) within 120 days of receipt are subject to a charge of 10 percent interest per annum.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you, unless you request when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee, or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Automated Information Line

You may access Delta Dental's automated information line at 800-693-2589 on a regular business day to obtain your eligibility and Benefits, group benefit or claim status information or to speak to a Customer Service Representative for assistance, including the resolution of complaints.

Conformity With Prevailing Laws

All legal questions about the Contract will be governed by the state of Florida where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the laws of Florida or federal law is hereby amended to conform to the minimum requirements of such laws.

ATTACHMENT A

Deductibles, Maximums and Contract Benefit Levels – High Plan

PLAN:
You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:

Service Category	***In-Network Delta Dental PPO Providers***	***Out-of-Network Delta Dental Premier and Non-Delta Dental Providers***
Diagnostic and Preventive:	100%	100%
Basic Benefits:	80%	80%
Major Benefits:	50%	50%
Orthodontic Benefits:	50%	50%

DEDUCTIBLE:

	In-Network	***Out-of-Network Delta Dental Premier and Non-Delta Dental Providers***
Per Enrollee Per Calendar Year	$50	$50
For All Family Members Per Calendar Year	$150	$150

In-Network - Deductible applies to Basic and Major Benefits.

Out-of-Network – Deductible applies to Diagnostic and Preventive, Basic and Major Benefits.

MAXIMUMS:

Orthodontic Lifetime Maximum per Enrollee	$1500	$1500
Calendar Year Maximum per Enrollee For Non-Orthodontic Benefits	$1500	$1500

ATTACHMENT B

Services, Limitations and Exclusions – High Plan

BENEFITS AND LIMITATIONS
Delta Dental will pay or otherwise discharge the percentage of Maximum Contract Allowance shown on Attachment A for covered services.

Diagnostic and Preventive Benefits and Limitations:
- Oral exams but not more than twice in a Calendar Year
- Full mouth or panoramic x-rays but not more than once every 36 months
- Bitewing x-rays but not more than twice per Calendar Year
- Cleaning of teeth (oral prophylaxis) but not more than twice in a Calendar Year
- Topical fluoride treatment twice in a Calendar Year for a dependent child 19 years of age or younger
- For dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 24 months
- For dependent children 19 years of age or younger, space maintainers

Basic Benefits and Limitations:
- Intraoral-periapical x-rays and other x-rays not specified under Diagnostic and Preventive Benefits
- Pulp vitality tests
- Diagnostic casts
- Bacteriological studies for determinations of pathological agents
- Initial placement of amalgam or composite fillings
- Replacement of an existing amalgam or composite fillings
- Sedative fillings
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Periodontal maintenance where periodontal treatment (including scaling, root planning and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four (4) times per Calendar Year less the number of teeth cleanings received during such Calendar Year.
- Emergency palliative treatment to relieve tooth pain

Major Benefits and Limitations:
- Prefabricated stainless steel crown or prefabricated resin crown, but not more than one per tooth within two (2) years
- Repair or re-cementing of Cast Restorations (Cast Restoration means an inlay, onlay or crown.)
- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period
- Periodontal scaling and root planing but not more than once per quadrant in any 24 month period
- Initial installation of Cast Restorations
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within five (5) years
- Oral surgery except as mentioned elsewhere
- Pulp therapy and apexification/recalcification
- Extractions of unimpacted teeth and removal of exposed roots
- Extractions of impacted teeth
- Root canal treatment but not more than once in a 24 month period for same tooth
- Initial installation of full or removable Dentures (Denture means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.)
- Addition of teeth to a partial removable Denture to replace natural teeth removed while covered dental services are in effect for the Enrollee receiving such services
- Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to replacement

- Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture
- Repair of Dentures
- Relinings and rebasings of existing removable Dentures if at least six (6) months have passed since the installation of the existing removable Denture and not more than once in any 36 month period
- Other removable prosthetic services not described elsewhere
- Other fixed Denture prosthetic services not described elsewhere
- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of five (5) years
- Adjustments of Dentures, if at least six (6) months have passed since the installation of the Denture
- Administration of general anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures
- Consultations, but not more than twice in a Calendar Year
- Injections of therapeutic drugs
- Local chemotherapeutic agents
- Fixed removable appliances for correction of harmful habits

Orthodontic Benefits and Limitations:
- Orthodontic Services mean procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of misalignment of teeth and/or jaws which significantly interferes with their functions
- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on Attachment A
- Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility
- Benefits are not paid to repair or replace any orthodontic appliance received under this program
- Benefits are not provided for orthodontic retreatment procedures

Note on additional benefits during pregnancy - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:
- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration; or
- a composite restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS

- Treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law
- Cosmetic surgery or dentistry for purely cosmetic reasons

- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity
- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment
- Any Single Procedure started prior to the date the Enrollee became covered for such services under this program
- Prescribed drugs, medication, pain killers or experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues)
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments
- Services or supplies covered by any other health plan of the Contractholder
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption
- Services for any disturbances of the temporomandibular (jaw) joints
- Replacement of a lost, missing or stolen crown, bridge or denture
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Temporary or provisional restoration
- Temporary or provisional appliance
- Adjustment of a denture or a bridgework which is made within six (6) months after installation by the same Dentist who installed it
- Any duplicate appliance or prosthetic device
- Charges made by a Dentist for failure to keep a scheduled visit with such Dentist
- Sterilization supplies
- Implantology
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards

ATTACHMENT C

Deductibles, Maximums and Contract Benefit Levels – Standard Plan

PLAN:
You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:

Service Category	*In-Network Delta Dental PPO Providers*	*Out-of-Network Delta Dental Premier and Non-Delta Dental Providers*
Diagnostic and Preventive:	We will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment.	90%
Basic Benefits:	We will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment.	60%
Major Benefits:	We will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment.	30%
Orthodontic Benefits:	We will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment.	50%

Enrollee Copayments can be found on the Table of Enrollee Copayments located in Attachment C-1.

DEDUCTIBLE:

	In-Network	*Out-of-Network Delta Dental Premier and Non-Delta Dental Providers*
Per Enrollee Per Calendar Year	None	$50
For All Family Members Per Calendar Year	None	$150

Deductible applies to Diagnostic and Preventive, Basic and Major Benefits.

MAXIMUMS:

Orthodontic Lifetime Maximum per Enrollee	Not Applicable*	$1500
Calendar Year Maximum per Enrollee For Non-Orthodontic Benefits	$1500	$1500

* We will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment for Orthodontics per treatment.

ATTACHMENT C-1

Table of Enrollee Copayments – Standard Plan

Please note the following:

- The services listed in the Table of Enrollee Copayments are considered In-Network Benefits when provided by a PPO Dentist.
- When provided by a PPO Dentist, Delta Dental will pay the Maximum Contract Allowance less the Enrollee Copayment for covered services listed in the Table of Enrollee Copayments.
- All covered services are subject to the limitations and exclusions listed in this Contract.
- Delta Dental's administration of benefits, limitations and exclusions under this plan at all times shall be based on the current version of Current Dental Terminology (CDT) whether or not a revised table is provided.

Notice: Delta Dental reserves the right to review and amend the Table of Enrollee Copayments annually and Enrollees should verify the most recent version is being referenced prior to receiving services.

Service Category	Description	Enrollee Copayment
Diagnostic	Periodic Exam	$ 0
	Exam	$ 5
	Full Mouth and Bitewing X-Rays	$ 0
	Periapical first film and occlusal	$ 9
	Extraoral X-ray	$ 25
	Additional periapicals	$ 3
Preventive	Prophylaxis	$ 15
	Fluoride	$ 0
	Sealants	$ 15
	Space Maintainers – unilateral	$ 105
	Space Maintainers - bilateral	$ 170
Restorative	Amalgams – primary	$ 35
	Amalgams – 1 Surface	$ 35
	Amalgams – 2 Surfaces	$ 45
	Amalgams – 3 or More Surfaces	$ 55
	Resin-based composite, anterior, 1 Surface	$ 40
	Resin-based composite, anterior, 2 Surfaces	$ 50
	Resin-based composite, anterior, more than 2 surfaces	$ 70
	Resin-based composite crown	$ 115
	Resin-based posterior composite	$ 45
	Inlays	$ 330
	Crowns/Onlays, Metal/Porcelain	$ 475
	Recementation – Inlays/Crowns	$ 35
	Prefabricated Crowns	$ 95
	Resin Windows	$ 125
	Post and Cores	$ 125
	Prefabricated Crowns/Post and Cores, each additional	$ 10
	Sedative Filling	$ 35
	Core buildup, including any pins	$ 85
	Cast post and core	$ 175
	Crown repairs	$ 90
	Recementation - Bridges	$ 55

Service Category	Description	Enrollee Copayment
Endodontics	Pulpal therapy	$ 30
	Root canal, anterior	$ 300
	Root canal, bicuspid	$ 355
	Root canal, molar	$ 490
	Root canal retreatment, anterior	$ 390
	Root canal retreatment, bicuspid	$ 450
	Root canal retreatment, molar	$ 550
	Apexification, initial	$ 130
	Apexification, interim	$ 70
	Apexification, final	$ 195
	Apicoectomy	$ 300
	Apicoectomy, additional root	$ 150
	Root amputation/hemisection	$ 200
Periodontics	Soft tissue surgery – gingivectomy (per quadrant)	$ 210
	Gingivectomy – per tooth	$ 60
	Gingival Flap Proc: more than 3 teeth/quad	$ 250
	Gingival Flap Proc: less than 3 teeth/quad	$ 150
	Apically Positioned Flap	$ 135
	Clinical crown lengthening	$ 350
	Osseous surgery	$ 460
	Osseous surgery (1-3 teeth)	$ 275
	Bone replacement graft – first site in quadrant	$ 105
	Bone replacement graft – each additional site in quadrant	$ 55
	Guided tissue regeneration	$ 190
	Surgical revision per tooth	$ 60
	Pedicle Soft Tissue Grafts	$ 290
	Other Soft Tissue Grafts	$ 410
	Soft tissue surgery – Distal or Proximal Wedge	$ 135
	Scaling and root planing (per quadrant)	$ 85
	Scaling and root planing (1-3 teeth)	$ 50
	Periodontal maintenance	$ 40
Prosthodontics (Removable)	Complete dentures	$ 535
	Partial dentures – resin base	$ 420
	Partial dentures – cast metal base	$ 820
	Denture adjustments	$ 30
	Denture repairs	$ 80
	Denture rebase	$ 205
	Denture reline – Chairside/Office	$ 105
	Denture reline – Lab	$ 165
	Tissue conditioning	$ 65
Prosthodontics (Fixed)	Fixed partial denture pontics	$ 435
	Retainer	$ 205
	Fixed partial denture repair	$ 70

Service Category	Description	Enrollee Copayment
Oral Surgery	Simple extractions	$ 50
	Surgical removal of erupted tooth	$ 105
	Removal of impacted tooth, soft tissue/partial bony	$ 145
	Removal of impacted tooth, full bony	$ 200
	Surgical exposure of impacted or unerupted tooth to aid eruption	$ 175
	Alveoloplasty with an extraction	$ 95
	Alveoloplasty without an extraction	$ 145
	Incision and drainage, Intraoral	$ 65
	Incision and drainage, Extraoral	$ 110
	Frenulectomy	$ 125
	Excision of hyperplastic tissue	$ 160
	Excision of pericoronal gingiva	$ 70
Adjunctive General Services	Palliative treatment	$ 25
	General Anesthesia or intravenous sedation, first 30 minutes	$ 155
	General Anesthesia, each additional 15 minutes	$ 60
	Intravenous sedation, each additional 15 minutes	$ 35
	Consultation	$ 40
	Occulusal adjustment – limited	$ 40
	Occlusal adjustment - complete	$ 195
Orthodontics	Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of misalignment of teeth and/or jaws which significantly interferes with their functions	$ 2,100

ATTACHMENT D

Services, Limitations and Exclusions – Standard Plan

BENEFITS AND LIMITATIONS
When provided by a PPO Dentist, Delta Dental will pay the Contract Allowance less the Enrollee Copayment for covered services listed on the Table of Enrollee Copayments shown on Attachment C-1 subject to limitations and exclusions. Enrollees are responsible for paying the Enrollee Copayment to the PPO Dentist.

When provided by a Delta Dental Premier or Non-Delta Dental Dentist, Delta Dental will pay or otherwise discharge the percentage of Maximum Contract Allowance shown on Attachment C page for covered services.

Diagnostic and Preventive Benefits and Limitations:
- Oral exams but not more than twice in a Calendar Year
- Full mouth or panoramic x-rays but not more than once every 36 months
- Bitewing x-rays but not more than twice per Calendar Year
- Cleaning of teeth (oral prophylaxis) but not more than twice in a Calendar Year
- Topical fluoride treatment twice in a Calendar Year for a dependent child 19 years of age or younger

Basic Benefits and Limitations:
- Intraoral-periapical x-rays and other x-rays not specified under Diagnostic and Preventive Benefits
- Pulp vitality tests
- Diagnostic casts
- Bacteriological studies for determinations of pathological agents
- For dependent children 19 years of age or younger, space maintainers
- Initial placement of amalgam or composite fillings
- Replacement of an existing amalgam or composite fillings
- Sedative fillings
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Periodontal maintenance where periodontal treatment (including scaling, root planning and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four (4) times per Calendar Year less the number of teeth cleanings received during such Calendar Year.
- Emergency palliative treatment to relieve tooth pain
- For dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 24 months

Major Benefits and Limitations:
- Prefabricated stainless steel crown or prefabricated resin crown, but not more than one per tooth within two (2) years
- Repair or re-cementing of Cast Restorations (Cast Restoration means an inlay, onlay or crown.)
- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period
- Periodontal scaling and root planing but not more than once per quadrant in any 24 month period
- Initial installation of Cast Restorations
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within five (5) years
- Oral surgery except as mentioned elsewhere
- Pulp therapy and apexification/recalcification
- Extractions of unimpacted teeth and removal of exposed roots
- Extractions of impacted teeth
- Root canal treatment but not more than once in a 24 month period for same tooth
- Initial installation of full or removable Dentures (Denture means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.)
- Addition of teeth to a partial removable Denture to replace natural teeth removed while covered dental services are in effect for the Enrollee receiving such services

- Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to replacement
- Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture
- Repair of Dentures
- Relinings and rebasings of existing removable Dentures if at least six (6) months have passed since the installation of the existing removable Denture and not more than once in any 36 month period
- Other removable prosthetic services not described elsewhere
- Other fixed Denture prosthetic services not described elsewhere
- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of five (5) years
- Adjustments of Dentures, if at least six (6) months have passed since the installation of the Denture
- Administration of general anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures
- Consultations, but not more than twice in a Calendar Year
- Injections of therapeutic drugs
- Local chemotherapeutic agents
- Fixed removable appliances for correction of harmful habits

Orthodontic Benefits and Limitations:
- Orthodontic Services mean procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of misalignment of teeth and/or jaws which significantly interferes with their functions
- Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility
- Benefits are not paid to repair or replace any orthodontic appliance received under this program
- Benefits are not provided for orthodontic retreatment procedures

Note on additional benefits during pregnancy - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:
- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration; or
- a composite restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS

- Treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law
- Cosmetic surgery or dentistry for purely cosmetic reasons
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the

teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity

- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment
- Any Single Procedure started prior to the date the Enrollee became covered for such services under this program
- Prescribed drugs, medication, pain killers or experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues)
- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision
- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments
- Services or supplies covered by any other health plan of the Contractholder
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption
- Services for any disturbances of the temporomandibular (jaw) joints
- Replacement of a lost, missing or stolen crown, bridge or denture
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Temporary or provisional restoration
- Temporary or provisional appliance
- Adjustment of a denture or a bridgework which is made within six (6) months after installation by the same Dentist who installed it
- Any duplicate appliance or prosthetic device
- Charges made by a Dentist for failure to keep a scheduled visit with such Dentist
- Sterilization supplies
- Implantology
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards