



**Delta Dental of North Carolina**  
4242 Six Forks Road, Suite 970  
Raleigh, NC 27609

## AGREEMENT AND CONSIDERATION

Your dental coverage is underwritten by Delta Dental of North Carolina, a North Carolina dental service corporation (hereinafter referred to as "Delta Dental"). Delta Dental will pay Benefits for Covered Services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first premium. It takes effect on the Effective Date shown on your Summary of Dental Plan Benefits. It will remain in force for such further periods for which it is renewed automatically upon payment of the required premium as set forth in your application for coverage. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

## 10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied, you may return the Policy within 10 days after you received it. Mail or deliver it to Delta Dental or to your agent. Any premium paid will be refunded. This Policy will then be void from its start. If you are eligible for Medicare by reason of age and purchased this Policy directly from Delta Dental without using an agent, this return period is extended to 30 days.

This Policy is signed for the Underwriting Company, Delta Dental of North Carolina, as of its Effective Date.

  
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President & CEO  
Delta Dental of North Carolina

**This Policy Has Been Certified by the Health Insurance Marketplace as Meeting the Essential Coverage Requirements for Pediatric Dental Services as Part of the Essential Health Benefits in Accordance with the Affordable Care Act.**

**THIS DENTAL POLICY IS CONDITIONALLY RENEWABLE REFER TO RENEWABILITY AND TERMINATION PROVISION**

**THIS POLICY IS A PPO DENTAL PLAN**

**IMPORTANT CANCELLATION INFORMATION— PLEASE READ THE PROVISIONS ENTITLED "CONDITIONALLY RENEWABLE-PREMIUM MAY CHANGE" AND "TERMINATION." READ YOUR POLICY AND SUMMARY OF DENTAL PLAN BENEFITS CAREFULLY**

**This Policy is a legal contract between the Insured and Delta Dental of North Carolina**



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## Delta Dental PPO<sup>SM</sup> (Standard) Summary of Dental Plan Benefits Low Plan C

This Summary of Dental Plan Benefits should be read along with your Policy. Your Policy provides additional information about your Delta Dental plan, including information about plan exceptions and reductions. If a statement in this Summary conflicts with a statement in the Policy, the statement in this Summary applies to you and you should ignore the conflicting statement in the Policy. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.\*

**THIS DOCUMENT IS INTENDED TO SERVE AS AN EXAMPLE AND IS NOT AN ACTUAL POLICY. UPON COMPLETION OF YOUR ENROLLMENT YOU WILL RECEIVE AN ACTUAL COPY OF YOUR POLICY**

Covered Services provided under your Policy are divided into two general categories: Non-EHB Covered Services and EHB Covered Services. EHB Covered Services are Essential Health Benefits, as that term is defined by the Patient Protection and Affordable Care Act ("PPACA"), and are available for individuals age 18 and under. EHB Covered Services are subject to specific Out-of-Pocket Maximums, Maximum Payments, Deductibles and frequency limitations. You will find these Out-of-Pocket Maximums, Maximum Payments, Deductibles and frequency limitations, as well as a listing of all specific procedures that will be administered as EHB Covered Services, at the end of this Summary under the heading "EHB Covered Services". Please note, in no event will the general frequency limitations found in your Policy apply to any of the EHB Covered Services listed in this Summary of Dental Plan Benefits. The remaining general exceptions and reductions found in your Policy shall only apply to EHB Covered Services to the extent those general exceptions and reductions do not conflict with the specific Out-of-Pocket Maximums, Maximum Payments, Deductibles, and frequency limitations found in this Summary of Dental Plan Benefits. An individual will be considered age 18 and under until the end of the Benefit Year/policy year in which the individual attains the age of 19.

As noted above, your Policy also covers Non-EHB Covered Services. Non-EHB Covered Services are available for eligible individuals regardless of age. For individuals 19 years of age or older, all procedures covered under your Policy are considered Non-EHB Covered Services. For individuals age 18 and under, Non-EHB Covered Services includes only those procedures that are covered under your Policy **which are not** specifically listed as EHB Covered Services at the end of this Summary. Non-EHB Covered Services are subject to specific Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations. You will find these Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations immediately following this paragraph under the heading "Non-EHB Covered Services".

**Non-EHB Covered Services**

Include all Covered Services that are not Essential Health Benefit (EHB) as defined by the Patient Protection and Affordable Care Act.

|   | In-Network Dentist                    |                              | Out-of-Network Dentist    | Waiting Period |
|---|---------------------------------------|------------------------------|---------------------------|----------------|
|   | Delta Dental PPO Dentist              | Delta Dental Premier Dentist | Non-participating Dentist |                |
|   | Plan Pays                             | Plan Pays*                   | Plan Pays*                |                |
| <b>Diagnostic &amp; Preventive</b>  |                                       |                              |                           |                |
| <b>Diagnostic and Preventive Services</b> - exams, cleanings, fluoride, and space maintainers | 80%                                   | 80%                          | 80%                       | NONE           |
| <b>Brush Biopsy</b> - to detect oral cancer   | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Emergency Palliative Treatment</b> - to temporarily relieve pain                           | 100%                                  | 100%                         | 100%                      | NONE           |
| <b>Radiographs</b> - X-rays   | 80%                                   | 80%                          | 80%                       | NONE           |
| <b>Sealants</b> - to prevent decay of permanent teeth   | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Basic Services</b>   |                                       |                              |                           |                |
| <b>Minor Restorative Services</b> - fillings and crown repair                                 | 50%                                   | 50%                          | 50%                       | 6 months       |
| <b>Oral Surgery Services</b> - extractions and dental surgery                                 | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Endodontic Services</b> - root canals  | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Periodontic Services</b> - to treat gum disease  | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Relines and Repairs</b> - prosthetic devices   | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Other Basic Services</b> - misc. services  | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Major Services</b>   |                                       |                              |                           |                |
| <b>Major Restorative Services</b> - crowns  | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Prosthetic Services</b> - bridges, dentures, and crowns over implants                      | 0%                                    | 0%                           | 0%                        | NOT COVERED    |
| <b>Maximum Payments &amp; Deductibles</b>   |                                       |                              |                           |                |
| <b>Benefit Year Maximum Payment</b>   | \$500                                 |                              |                           |                |
| <b>Deductible (per Benefit Year)</b>  | \$50 per person;<br>\$150 per family; |                              |                           |                |

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference. **With this plan, you are strongly encouraged to obtain dental services from a Delta Dental PPO Dentist in order to maximize your benefits and reduce your out-of-pocket costs.**

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Bitewing X-rays are payable once per Benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any five year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.

- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payments for Non-EHB Covered Services** – \$500 per person total per Calendar Year on all services.

**Out-of-Pocket Maximum Payment for Non-EHB Covered Services** – An Out-of-Pocket Maximum is the maximum amount that you or your Eligible Dependent will pay for Covered Services throughout a Benefit Year. There is no Annual Out-of-Pocket Maximum Payment for Non-EHB Covered Services. You will be responsible for all Coinsurance, Copayments, Deductibles and other out-of-pocket expenses associated with all Non-EHB Covered Services provided to you or your Eligible Dependent throughout the Benefit Year.

**Deductible for Non-EHB Covered Services** – The Deductible per individual per Benefit Year is \$50, limited to a maximum of \$150 per family per Benefit Year.

**Waiting Period for Non-EHB Covered Services**– Individuals will be eligible for coverage for Diagnostic and Preventive, Basic, and Major Services in accordance with the applicable Waiting Periods set forth in the Covered Services chart above, measured from your or their date of coverage under this Policy.

Eligible Dependents enrolled after your date of enrollment will have their own waiting period in accordance with the above.

**Eligibility** - You and your Eligible Dependents, including your Domestic Partner are also eligible for coverage under this Policy.

A Domestic Partner is defined as follows and shall be treated as a “legal spouse” under the terms of the Policy:

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age or older and competent to enter into a contract in the state in which they reside;
- both parties currently share a common legal residence and have shared said residence for at least six months prior to application for Domestic Partner coverage;
- neither party is married to anyone other than the other or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- both parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household-the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

You and your Eligible Dependents must enroll for a minimum of 12 months. If Coverage is terminated prior to completing 12 months, you may not re-enroll for at least 12 months from the date of termination.

If you and your Legal Spouse are both eligible for coverage under this Plan, you may be enrolled together on one application or separately on individual applications, but not both. Your Children may only be enrolled on one application.

**Payment of Claims**

While your Policy may pay the same percentage of Benefits for certain procedures regardless of whether you use a Delta Dental PPO Dentist or a Delta Dental Premier Dentist, your costs will generally be lower when you use a PPO Dentist. Delta Dental PPO Dentists and Delta Dental Premier Dentists have agreed to accept the pre-negotiated fee as payment in full. This limits your cost to the percentage of Coinsurance listed, along with any applicable deductible. A Nonparticipating Dentist has not agreed to accept the pre-negotiated fee as payment in full, and payment is based on an average of the rate charged by Dentists for that procedure in the area. If your Nonparticipating Dentist charges a rate higher than this average, you may be required to pay more than the percentage listed.

Emergency services that are not reasonably available from a Delta Dental Participating Dentist without an unreasonable delay will be treated as if they had been provided by a Delta Dental PPO Dentist.

For example, if a claim is submitted for several diagnostic and preventive services, along with radiographs, totaling \$1,000:

**(For demonstration purposes only—Costs will vary based on your situation)**

|   | In-Network Service        |                               | Out-of-Network Service     |
|---|---------------------------|-------------------------------|----------------------------|
|   | Delta Dental PPO Dentists | Delta Dental Premier Dentists | Non-participating Dentists |
| Charges Submitted by the Dentist  | \$1,000                   | \$1,000                       | \$1,000                    |
| Pre-Negotiated Fee  | \$750                     | \$800                         | N/A                        |
| Allowed Amount  | \$750                     | \$800                         | \$850                      |
| Charges higher than the Allowed Amount that are your responsibility                               | \$0                       | \$0                           | \$150                      |
| Percentage listed in the Plan Pays column   | 100%                      | 100%                          | 100%                       |
| Amount Paid by Delta Dental   | 100% x \$750 = \$750      | 100% x \$800 = \$800          | 100% x \$850 = \$850       |
| Percentage listed in You Pay column   | 0%                        | 0%                            | 0%                         |
| Dollar amount, based on the percentage listed in the You Pay column, which is Your responsibility | 0% x \$750 = \$0          | 0% x \$800 = \$0              | 0% x \$850 = \$0           |

|   |                       |                       |                        |
|---|-----------------------|-----------------------|------------------------|
| Your Total Cost:<br>(The cost over the Allowed Amount PLUS the dollar amount based on the percentage in the You Pay Column) | $\$0 + \$0 = \$0$     | $\$0 + \$00 = \$0$    | $\$150 + \$00 = \$150$ |
| Savings for using a Premier Dentist instead of a Non-PPO Dentist:   | N/A                   | $\$150 - \$0 = \$150$ | N/A                    |
| Savings for using a Delta Dental PPO Dentist instead of a Non-PPO Dentist:  | $\$150 - \$0 = \$150$ | N/A                   | N/A                    |

**NOTICE:** Your actual expenses for Covered Services may exceed the stated Coinsurance percentage because actual provider charges may not be used to determine Delta Dental's and your payment obligations.

The fee schedules are different for PPO Dentists and Premier Dentists. Generally, Delta Dental pays the Dentist the agreed upon fee, based on the applicable fee schedule and the Dentist agrees to accept that amount as payment in full. However, as noted in the "How the Payment Is Made" section of the Certificate, for the Standard PPO (Low) plan, Delta Dental pays Premier Dentists based on the PPO Fee Schedule and the individual is responsible for any difference between the PPO Fee Schedule and the Premier Fee Schedule for that Covered Service. Please see the example contained in the Summary of Dental Plan Benefits.

| EHB Covered Services<br>(for individuals age 18 and under)                                    | In-Network Dentist |            | Out-of-Network Dentist |
|---|--------------------|------------|------------------------|
|   | Plan Pays          | Plan Pays* | Plan Pays*             |
| <b>Diagnostic &amp; Preventive</b>  |                    |            |                        |
| <b>Diagnostic and Preventive Services</b> - exams, cleanings, fluoride, and space maintainers | 100%               | 80%        | 80%                    |
| <b>Emergency Palliative Treatment</b> - to temporarily relieve pain                           | 100%               | 100%       | 100%                   |
| <b>Radiographs</b> - X-rays   | 100%               | 80%        | 80%                    |
| <b>Sealants</b> - to prevent decay of permanent teeth   | 100%               | 80%        | 80%                    |
| <b>Basic Services</b>   |                    |            |                        |
| <b>Minor Restorative Services</b> - fillings and crown repair                                 | 50%                | 50%        | 50%                    |
| <b>Oral Surgery Services</b> - extractions and dental surgery                                 | 50%                | 50%        | 50%                    |
| <b>Endodontic Services</b> - root canals  | 50%                | 50%        | 50%                    |
| <b>Periodontic Services</b> - to treat gum disease  | 50%                | 50%        | 50%                    |
| <b>Relines and Repairs</b> - prosthetic appliances  | 50%                | 50%        | 50%                    |
| <b>Other Basic Services</b> - misc. services  | 50%                | 50%        | 50%                    |
| <b>Major Services</b>   |                    |            |                        |
| <b>Major Restorative Services</b> - crowns  | 50%                | 50%        | 50%                    |

|  |     |     |     |
|--|-----|-----|-----|
| <b>Prosthodontic Services</b> - bridges, dentures and crowns over implants | 50% | 50% | 50% |
| <b>Orthodontic Services</b>  |     |     |     |
| <b>Orthodontic Services</b> -medically necessary only                      | 50% | 50% | 50% |

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference. **With this plan, you are strongly encouraged to obtain dental services from a PPO Dentist in order to maximize your benefits and reduce your out-of-pocket costs.**

**In-Network Annual Out-of-Pocket Maximum for EHB Covered Services** - An Out-of-Pocket Maximum is the maximum amount that you or an Eligible Person will pay for EHB Covered Services throughout a Benefit Year.

The In-Network Annual Out-of-Pocket Maximum for EHB Covered Services shall be \$350 per Benefit Year if this Policy covers one Eligible Person age 18 and under, or \$700 per Benefit Year if this Policy covers two or more Eligible Persons age 18 and under.

Any Coinsurance, Copayments, Deductibles, or other out-of-pocket expenses paid by an Eligible Person for In-Network EHB Covered Services shall count toward that In-Network Annual Out-of-Pocket Maximum. The Annual In-Network Out-of-Pocket Maximum will not include any amounts paid for the following: (i) premiums; (ii) for non-covered services; (iii) to Out-of-Network Dentists; (iv) Coinsurance, Copayments, Deductibles, or other out-of-pocket expenses for services other than EHB Covered Services; or (v) Coinsurance, Copayments, Deductibles, or other out-of-pocket expenses for EHB Covered Services provided to individuals 19 years of age and older. Once their applicable Annual In-Network Out-of-Pocket Maximum is reached for the Benefit Year, all In-Network EHB Covered Services provided to an Eligible Person will be covered at 100% of the Maximum Approved Fee.

**Out-of-Network Out-of-Pocket Maximum for EHB Covered Services** -There is no annual Out-of-Pocket Maximum for Out-of-Network EHB Covered Services. Eligible Persons will be responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network EHB Covered Services provided Eligible Persons throughout the Benefit Year.

**Annual and Lifetime Maximum Payments for EHB Covered Services**-There are no annual or lifetime Maximum Payments for EHB Covered Services under this Policy.

**Deductible for EHB Covered Services** -The Deductible is \$50 per individual per Benefit Year, limited to a maximum Deductible of \$150 for all per family per Benefit Year. The Deductible does not apply to Exams, Cleanings, Fluoride, Space Maintainers, Emergency Palliative treatment, Sealants, and Orthodontics.

**Waiting Period for EHB Covered Services** - There are no waiting periods for Eligible Persons age 18 and under seeking EHB Covered Services.

**EHB Covered Services**

The following services are the specific EHB Covered Services to the extent they are received by an individual age 18 and under:

**Class A**

**Diagnostic and Preventive Services**

**Examinations/Evaluations**

- D0120 - periodic oral evaluation
- D0140 - limited oral evaluation - problem focused
- D0145 - oral evaluation for a patient age 2 and under
- D0150 - comprehensive oral evaluation
- D0160 - detailed and extensive oral evaluation (problem focused)
- D0180 -comprehensive periodontal evaluation

❖ Benefits for the foregoing clinical oral evaluations are payable twice in any Benefit Year, whether provided under one or more Delta Dental plan(s).

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### Cleanings (Prophylaxes)

D1110 - prophylaxis - adult

D1120 - prophylaxis - child

- ❖ Benefits for prophylaxis including periodontal maintenance or scaling in the presence of moderate or severe gingival inflammation are payable twice in any Benefit Year. Benefits for full mouth debridement are payable once in a lifetime.

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### Fluoride Treatment

D1206 - topical fluoride varnish

D1208 - topical application of fluoride (prophylaxis not included)

- ❖ Benefits for topical application of fluoride are payable twice in any Benefit Year.

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### Space maintainers

D1510 - space maintainer - fixed - unilateral

D1516 - space maintainer - fixed - bilateral, maxillary

D1517 - space maintainer - fixed - bilateral, mandibular

D1520 - space maintainer - removable - unilateral

D1526 - space maintainer - removable - bilateral, maxillary

D1527 - space maintainer - removable - bilateral, mandibular

D1550 - re-cementation of space maintainer

D1575 - distal shoe - fixed, unilateral, up to age 9

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### Emergency Palliative Treatment

D9110 - palliative (emergency) treatment

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### Radiographs (X-rays)

D0210 - intraoral-complete series (including bitewings)

D0330 - panoramic film

- ❖ Benefits for a complete intraoral radiographic series (including bitewing radiographs) or a panoramic film (with/or without bitewing films) are payable once in any five-year period.

D0220 - intraoral-periapical first film

D0230 - intraoral-periapical each addl film

D0240 - intraoral-occlusal film

D0270 - bitewing - single film

D0272 - bitewings - two films

D0273 - bitewings - three films

D0274 - bitewings - four films

D0277 - bitewing, vertical, 7 to 8 films

- ❖ Benefits for bitewing images (posterior or vertical) are payable twice in any Benefit Year.

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### Sealants

D1351 - Sealant - per tooth - unrestored permanent molars

- ❖ Sealants are payable only for the occlusal (biting) surface of unrestored permanent molars, free from decay and restorations.

- ❖ Sealants are a Benefit payable once in any three-year period per tooth.

D1352 - Preventive resin restorations in a moderate to high caries risk patient - permanent tooth

- ❖ Payable one sealant per tooth in any three-year period.

D1353- sealant repair-per tooth

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## Class B Basic Services



**Minor Restorative Services** (local anesthesia is considered to be part of restorative procedures)

- D2140 - amalgam - one surface, primary or permanent
  - D2150 - amalgam - two surfaces, primary or permanent
  - D2160 - amalgam - three surfaces, primary or permanent
  - D2161 - amalgam - four or more surfaces, primary or permanent
  - D2330 - resin-based composite - one surface, anterior
  - D2331 - resin-based composite - two surfaces, anterior
  - D2332 - resin-based composite - three surfaces, anterior
  - D2335 - resin-based composite - four or more surfaces (anterior)
    - ❖ Tooth preparations, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration.
    - ❖ Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration.
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- D2910 - recement inlay, only or partial coverage restoration
  - D2915 - recement cast or prefabricated post and core
  - D2920 - recement crown
  - D2980 - crown repair
  - D2981 - inlay repair
  - D2982 - onlay repair
  - D2983 - veneer repair
  - D2990 - resin infiltration/smooth surface
    - ❖ Limited to 1 in any 36 month period
  - D2929 - prefabricated porcelain crown - primary tooth
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- D2930 - prefabricated stainless steel crown - primary tooth
  - D2931 - prefabricated stainless steel crown - permanent tooth
    - ❖ Stainless steel and porcelain crowns are payable once per tooth in any five-year period.
    - ❖ Benefits for stainless steel crowns with esthetic facings, veneers or coatings are optional treatment. Delta Dental will only pay the amount that it would pay for a conventional stainless steel crown.
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- D2940 - sedative filling
  - D2951 - pin retention - per tooth, in addition to restoration
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**Oral Surgery Services**

- D7111 - extraction, coronal remnants - primary tooth
- D7140 - extraction, erupted tooth or exposed root
- D7210 - removal of erupted tooth D7220 - removal of impacted tooth - soft tissue
- D7230 - removal of impacted tooth - partial bony
- D7240 - removal of impacted tooth - completely bony
- D7241 - removal of impacted tooth - completely bony, with unusual surgical complications
- D7250 - removal of residual tooth roots
- D7251 - coronectomy - intentional partial tooth removal
- D7270 - tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- D7280 - exposure of an unerupted tooth
- D7282 - mobilization of erupted or malpositioned tooth to aid eruption
- D7283 - placement of device to facilitate eruption of impacted tooth
- D7310 - alveoloplasty in conjunction with extractions - four or more teeth per quadrant

D7311 – alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant  
D7320 – alveoplasty not in conjunction with extractions – four or more teeth per quadrant  
D7321 – alveoplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant  
D7471 – removal of exostosis  
D7510 – incision and drainage of abscess – intraoral soft tissue  
D7910 – suture of recent small wounds up to 5 cm  
D7953 – bone replacement graft for ridge preservation – per site  
D7971 – excision of pericoronal gingiva

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### Endodontic Services

D3220 – therapeutic pulpotomy (excluding final restoration)  
D3221 – pulpal debridement, primary or permanent teeth  
D3222 – Partial Pulpotomy for Apexogenesis – permanent tooth with incomplete root development  
\*\*\* If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a Covered Service as it is considered a part of the root canal procedure and Benefits are not payable separately.

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D3230 – pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)  
D3240 – pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)  
❖ Benefit for root canal fillings on primary teeth are limited to primary teeth without succedaneous (replacement) teeth.

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D3310 – anterior (excluding final restoration)  
D3320 – premolar (excluding final restoration)  
D3330 – molar (excluding final restoration)  
D3346 – retreatment of previous root canal therapy – anterior  
D3347 – retreatment of previous root canal therapy – premolar  
D3348 – retreatment of previous root canal therapy – molar  
D3351 – apexification/recalcification – initial visit (apical closure/calcific repair or perforations, root resorptions)  
D3352 – apexification/recalcification – interim visit D3353 – apexification/recalcification – final visit D3355 – Pulpal regeneration – initial visit  
D3356 – pulpal regeneration – interim medication replacement  
D3357 – pulpal regeneration – completion of treatment  
D3410 – apicoectomy surgery – anterior  
D3421 – apicoectomy surgery – premolar (first root)  
D3425 – apicoectomy surgery – molar (first root)  
D3426 – apicoectomy surgery – (each addl root)  
D3430 – retrograde filling- per root  
D3450 – root amputation – per root  
D3920 – hemisection (including any root removal),

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### Periodontic Services

D4210 – gingivectomy or gingivoplasty – four or more teeth  
D4211 – gingivectomy or gingivoplasty – one to three teeth  
D4212 – gingivectomy or gingivoplasty – to allow access for restorative procedures  
D4240 – gingival flap procedure, including root planing – four or more teeth  
D4241 – gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth or bounded teeth spaces  
D4260 – osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant

- D4261 - osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant
- ❖ Benefits for the foregoing periodontal surgical services are payable once in any three-year period.
- D4263 - bone replacement graft - retained natural tooth - first site in quadrant
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- D4249 - clinical crown lengthening - hard tissue
- D4270 - pedicle soft tissue graft procedure
- D4273 - autogenous connective tissue graft procedures (including donor site surgery)
- D4275 - soft tissue allograft
- D4277 - free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position
- D4278 - free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth, implant or edentulous tooth position
- D4283 - autogenous connective tissue graft procedure (including donor site surgery) - each additional contiguous tooth, implant, or edentulous tooth position
- D4341 - periodontal scaling and root planing, four or more teeth
- D4342 - periodontal scaling and root planing, one to three teeth
- ❖ Benefits for the foregoing scaling and root planing are payable once, per quadrant, in any two-year period.
- D4346 - scaling in presence of moderate or severe gingival inflammation
- ❖ Benefits for prophylaxis including periodontal maintenance or scaling in the presence of moderate or severe gingival inflammation are payable twice in any Benefit Year. Benefits for full mouth debridement is payable once in a lifetime.
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D4355 - full mouth debridement Full mouth debridement is payable once per lifetime.

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- D4910 - periodontal maintenance procedures
- ❖ Benefits for periodontal maintenance following therapy, including adult prophylaxis are payable four times in any Benefit Year.
- D7921 - collect-apply autologous product
- ❖ Limited to 1 in any 36 month period
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### **Relines and Repairs**

- D5410 - adjust complete denture - maxillary
- D5411 - adjust complete denture - mandibular
- D5421 - adjust partial denture - maxillary
- D5422 - adjust partial denture - mandibular
- D5511 - repair broken complete denture base, mandibular
- D5512 - repair broken complete denture base, maxillary
- D5520 - replace missing or broken teeth - complete denture
- D5611 - repair resin denture base, mandibular
- D5612 - repair resin denture base, maxillary
- D5621 - repair cast partial framework, mandibular
- D5622 - repair cast partial framework, maxillary
- D5630 - repair or replace broken clasp, per tooth
- D5640 - replace broken teeth - per tooth
- D5650 - add tooth to existing partial denture
- D5660 - add clasp to existing partial denture, per tooth
- D5670 - replace all teeth and acrylic on cast metal framework (maxillary)
- D5671 - replace all teeth and acrylic on cast metal framework (mandibular)
- D5710 - rebase complete maxillary denture
- D5711 - rebase complete mandibular denture
- D5720 - rebase maxillary partial denture

D5721 – rebase mandibular partial denture  
D5730 – reline complete maxillary denture  
D5731 – reline complete mandibular denture  
D5740 – reline maxillary partial denture  
D5741 – reline mandibular partial denture  
D5750 – reline complete maxillary denture (laboratory)  
D5751 – reline complete mandibular denture (laboratory)  
D5760 – reline maxillary partial denture (laboratory)  
D5761 – reline mandibular partial denture (laboratory)  
❖ Benefits for the foregoing rebase and reline of a complete or partial denture base are payable once in any three-year period per appliance, six months after the initial installation

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D5850 – tissue conditioning denture (maxillary)  
D5851 – tissue conditioning denture (mandibular)

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D6930 – recement fixed partial denture  
D6980 – fixed partial denture repair by report

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#### Other Basic Services

D0340 – 2D cephalometric images  
D0350 – Oral/facial photographic images  
D0391 – interpretation of diagnostic image  
D0470 – diagnostic casts  
D9222 – deep sedation/general anesthesia – first 15 min  
D9223 – deep sedation/general anesthesia – each subsequent 15 min  
D9239 – intravenous conscious  
D9243 – intravenous conscious sedation/analgesia – each subsequent 15 min  
D9310 – consultation  
D9610 – therapeutic drug injection, single administration  
D9612 – therapeutic drug injection two or more administrations, different medications  
D9613 – infiltration of sustained release therapeutic drug – single or multiple sites  
D9930 – treatment of complications (post-surgical)  
D9940 D9944 – occlusal guard – hard appliance full arch, by report  
D9946 – occlusal guard – hard appliance partial arch, by report  
❖ Benefits for an occlusal guard are payable once per Benefit Year for individuals 13-18 years of age.

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#### Class C Major Services

##### Major Restorative Services

D2510 inlay – metallic – one surface, an alternate benefit will be provided  
D2520 inlay – metallic – two surfaces, an alternate benefit will be provided  
D2530 inlay – metallic – three surfaces, an alternate benefit will be provided  
D2542 – onlay – metallic – two surfaces  
D2543 – onlay – metallic – three surfaces  
D2544 – onlay – metallic – four or more surfaces  
D2710 – crown – resin-based composite (indirect)  
D2712 – crown – 3/4 resin-based composite (indirect)  
D2720 – crown – resin with high noble metal  
D2721 – crown – resin with predominantly base metal  
D2722 – crown – resin with noble metal  
D2740 – crown – porcelain/ceramic substrate  
D2750 – crown – porcelain fused to high noble metal  
D2751 – crown – porcelain fused to predominantly base metal  
D2752 – crown – porcelain fused to noble metal  
D2780 – crown – 3/4 cast high noble metal

- D2781 – crown – 3/4 cast predominantly base metal
- D2782 – crown – 3/4 cast noble metal
- D2783 – crown – 3/4 porcelain/ceramic
- D2790 – crown – full cast high noble metal
- D2791 – crown – full cast predominantly base metal
- D2792 – crown – full cast noble metal
- D2794 – crown – titanium
- D2950 – core buildup, including any pins
- D2952 – cast post and core in addition to crown
- D2954 – prefabricated post and core in addition to crown
  - ❖ Benefits for the foregoing onlays and crowns are payable once per tooth in any five-year period.
  - ❖ Benefits for core buildups, cast posts and cores and prefabricated posts are limited to one procedure per tooth
  - ❖ Benefits for plastic, resin, porcelain fused to metal, porcelain and porcelain/ceramic crowns or onlays on posterior teeth are optional treatment. Delta Dental will pay only the amount that it would pay for a full metal crown or metallic onlay.
  - ❖ Benefits for inlays, regardless of the material used are optional treatment. Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
  - ❖ Benefits for plastic, resin, porcelain fused to metal, porcelain and porcelain/ceramic crowns or onlays on posterior teeth are optional treatment. Delta Dental will pay only the amount that it would pay for a full metal crown or metallic onlay.
  - ❖ Benefits for inlays, regardless of the material used are optional treatment. Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

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#### Prosthodontic Services

- D5110 – complete denture – maxillary
- D5120 – complete denture – mandibular
- D5130 – immediate denture – maxillary
- D5140 – immediate denture – mandibular
  - ❖ Benefits for one complete upper and one complete lower denture are payable once in any five-year period.

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- D5211 – maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
  - D5212 – mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
  - D5213 – maxillary partial denture – cast metal framework- resin denture base (including any conventional clasps, rests and teeth)
  - D5214 – mandibular partial denture – cast metal framework- resin denture base (including any conventional clasps, rests and teeth)
  - D5221 – immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
  - D5222 – immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
  - D5223 – immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
  - D5224 – immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
  - D5225 – maxillary partial denture – flexible base (including any clasps, rests and teeth)
  - D5226 – mandibular partial denture – flexible base (including any clasps, rests and teeth)
  - D5282 – removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary
  - D5283 – removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular

- ❖ Benefits for a partial denture are payable only once per arch in any five-year period.
- ❖ Benefits for overdentures are optional treatment. Delta Dental will pay only the amount that it would pay for a conventional denture.

- D6010 - endosteal implant
- D6012 - surgical placement of interim implant body
- D6040 - eposteal implant
- D6050 - transosteal implant, including hardware
- D6053 - implant supported complete denture
- D6054 - implant supported partial denture
- D6055 - connecting bar - implant or abutment supported
- D6056 - Prefabricated abutment
- D6057 - custom abutment
- D6058 - abutment supported porcelain/ceramic crown
- D6059 - abutment supported porcelain fused to high noble metal
- D6060 - abutment supported porcelain fused to predominantly base metal crown
- D6061 - abutment supported porcelain fused to noble metal crown
- D6062 - abutment supported cast high noble metal crown
- D6063 - abutment supported cast predominantly base metal crown
- D6064 - abutment supported cast noble metal crown
- D6094 - abutment supported titanium crown
- D6096 - remove broken implant retaining screw
- D6065 - implant supported porcelain/ceramic crown
- D6066 - implant supported porcelain fused to high metal crown
- D6067 - implant supported metal crown
- D6068 - abutment supported retainer for porcelain/ceramic FPD
- D6069 - abutment supported retainer for porcelain fused to metal FPD
- D6070 - abutment supported retainer for porcelain fused to predominantly base metal FPD
- D6071 - abutment supported retainer for porcelain fused to noble metal FPD
- D6072 - abutment supported retainer for cast high noble metal FPD
- D6073 - abutment supported retainer for cast predominantly base metal FPD
- D6074 - abutment supported retainer for cast noble metal FPD
- D6194 - abutment supported retainer for titanium FPD
- D6075 - implant supported retainer for ceramic FPD
- D6076 - implant supported retainer for porcelain fused to high noble metal FPD
- D6077 - implant supported retainer for cast metal FPD
- D6080 - implant maintenance procedures
- D6090 - repair implant prosthesis
- D6091 - replacement of semi-precision or precision attachment
- D6092 - recement implant/abutment supported crown
- D6093 - recement implant/abutment supported fixed partial denture
- D6095 - repair implant abutment
- D6100 - implant removal
- D6101 - debridement periimplant defect,
- D6102 - debridement and osseous periimplant defect
- D6103 - bone graft periimplant defect
- D6104 - bone graft implant replacement
- D6114 - implant/abutment supported fixed denture for edentulous arch- maxillary
- D6115 - implant/abutment supported fixed denture for edentulous arch- mandibular
- D6116 - implant/abutment supported fixed denture for partially edentulous arch- maxillary
- D6117 - implant/abutment supported fixed denture for partially edentulous arch- mandibular
- D6190 - implant index
  - ❖ Benefits for the foregoing abutments and implants and related procedures are payable once in any five-year period.

Benefits for implant/abutment supported complete or partial dentures are optional treatment. Delta Dental will only pay the amount that it would pay for a conventional denture

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- D6205 - pontic - indirect resin based composite
  - D6210 - pontic - cast high noble metal
  - D6211 - pontic - cast predominantly base metal
  - D6212 - pontic - cast noble metal
  - D6214 - pontic - titanium
  - D6240 - pontic - porcelain fused to high noble metal
  - D6241 - pontic - porcelain fused to predominantly base metal
  - D6242 - pontic - porcelain fused to noble metal
  - D6245 - pontic - porcelain/ceramic
  - D6250 - pontic - resin with high noble metal
  - D6251 - pontic - resin with predominantly base metal
  - D6252 - pontic - resin with noble metal
  - D6545 - retainer - cast metal for resin bonded fixed prosthesis
  - D6548 - retainer - porcelain/ceramic for resin bonded fixed prosthesis
  - D6549 - resin retainer - for resin bonded fixed prosthesis
  - D6600 - inlay - porcelain/ceramic, two surfaces
  - D6601 - inlay - porcelain/ceramic, three or more surfaces
  - D6602 - inlay - cast high noble metal, two surfaces
  - D6603 - inlay - cast high noble metal, three or more surfaces
  - D6604 - inlay - cast predominantly base metal, two surfaces
  - D6605 - inlay - cast predominantly base, three or more surfaces
  - D6606 - inlay - cast noble metal, two surfaces
  - D6607 - inlay - cast noble metal, three or more surfaces
  - D6624 - inlay - titanium
  - D6608 - onlay - porcelain/ceramic, two surfaces
  - D6609 - onlay - porcelain/ceramic, three or more surfaces
  - D6610 - onlay - cast high noble metal, two surfaces
  - D6611 - onlay - cast high noble metal, three or more surfaces
  - D6612 - onlay - cast predominantly base metal, two surfaces
  - D6613 - onlay - cast predominantly base, three or more surfaces
  - D6614 - onlay - cast noble metal, two surfaces
  - D6615 - onlay - cast noble metal, three or more surfaces
  - D6634 - onlay - titanium
  - D6710 - crown - indirect resin based composite
  - D6720 - crown - resin with high noble metal
  - D6721 - crown - resin with predominantly base metal
  - D6722 - crown - resin with noble metal
  - D6740 - crown - porcelain/ceramic
  - D6750 - crown - porcelain fused to high noble metal
  - D6751 - crown - porcelain fused to predominantly base metal
  - D6752 - crown - porcelain fused to noble metal
  - D6780 - crown - 3/4 cast high noble metal
  - D6781 - crown - 3/4 cast predominantly base metal
  - D6782 - crown - 3/4 cast noble metal
  - D6783 - crown - 3/4 porcelain/ceramic
  - D6790 - crown - full cast high noble metal
  - D6791 - crown - full cast predominantly base metal
  - D6792 - crown - full cast noble metal
  - D6794 - crown - titanium
- ❖ Benefits for the foregoing pontics, inlays, onlays, retainers and crowns are payable only once in any five-year period.
  - ❖ Benefits for all porcelain/ceramic bridges are optional treatment. Delta Dental will only pay the amount that it would pay for a conventional fixed bridge.

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**Class D**

**Orthodontic Services**

- D8010 - limited orthodontic treatment of primary dentition
- D8020 - limited orthodontic treatment of transitional dentition
- D8030 - limited orthodontic treatment of adolescent dentition
- D8040 - limited orthodontic treatment of e adult dentition
- D8050 - interceptive orthodontic treatment of primary dentition
- D8060 - interceptive orthodontic treatment of transitional dentition
- D8070 - comprehensive orthodontic treatment of transitional dentition
- D8080 - comprehensive orthodontic treatment of adolescent dentition
- D8090 - comprehensive orthodontic treatment of adult dentition
- D8210 - removable appliance therapy
- D8220 - fixed appliance therapy
- D8660 - pre-orthodontic treatment visit
- D8670 - periodic orthodontic treatment visit (as part of contract)
  - ❖ Benefits for the foregoing Orthodontic Services are payable only to the extent said services are “medically necessary” and only for age 18 and under.

- 
- D8680 - orthodontic retention (removal of appliances, construction and placement of retainer(s))
    - ❖ Benefits for the foregoing Orthodontic Service are payable only to the extent said services are “medically necessary” and only for age 18 and under
    - ❖ Benefits for orthodontic retention are payable whether billed in conjunction with other orthodontic services or billed separately.
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SAMPLE



THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Delta Dental.

## TABLE OF CONTENTS

| SECTION                                     | PAGE(S) |
|---|---------|
| Summary of Dental Plan Benefits             |         |
| Cover.....                                  | 1       |
| Definitions.....                            | 2       |
| Insured Person's Eligibility.....           | 7       |
| Selecting A Dentist.....                    | 8       |
| Accessing Your Benefits.....                | 8       |
| Renewability and Termination of Policy..... | 10      |
| General Benefit Provisions.....             | 12      |
| Exceptions and Reductions.....              | 16      |
| Claim Provisions.....                       | 20      |
| General Provisions.....                     | 23      |
| Premiums.....                               | 25      |

## DEFINITIONS

- A. **Allowed Amount** - means the maximum dollar amount we will base Benefit payment upon for any Covered Service. We determine the Allowed Amount based on treatment rendered and fees charged by a sample of Dentists of similar training within your geographic area.
- B. **Benefit Year** - means the period during which any benefit frequency limitation and/or annual Maximum Payment will apply. This will be the calendar year beginning on January 1, unless otherwise shown on the Summary of Dental Plan Benefits.
- C. **Benefits** - means payment for Covered Services under the Policy.
- D. **Child(ren)** - means Your natural Children, stepchildren, adopted Children, foster Children placed in the foster home, Children required to be covered by a court order or administrative order, or Children by virtue of legal guardianship, regardless of age or dependency status, including Children residing with the you during the waiting period for legal adoption or guardianship. Eligibility for Essential Health Benefits for Children will continue until the end of the Benefit Year in which the Child(ren) turns 19 years of age.
- E. **Claim** - means a request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.
- F. **Coinsurance** - means the percentage of the Allowed Amount for Covered Services that the Insured must pay toward treatment.
- G. **Completion Dates** - The date that treatment is complete. Some procedures may require more than one appointment. Treatment is complete:
- For dentures and partial dentures, on the delivery date;
  - For crowns and bridgework, on the cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.
- H. **Copayment** - means the fixed amount you pay for a Covered Service.
- I. **Covered Services** - means the unique dental services selected for Benefits as described in the Summary of Dental Plan Benefits and subject to the terms and conditions of this Policy.
- J. **Deductible** - means the amount an individual and/or a family must pay toward Covered Services before Delta Dental begins paying for services under this Policy. The Deductible amount is shown in the Summary of Dental Plan Benefits.
- K. **Delta Dental** - means Delta Dental of North Carolina, a non-profit dental service corporation. Delta Dental of North Carolina is not a commercial insurance company.
- L. **Delta Dental Member Plan** - means a company that is a member of the Delta Dental Plans Association.
- M. **Delta Dental PPO Plus Delta Dental Premier (PPO Plus Premier)** - means Delta Dental's national preferred provider organization that can reduce the out-of-pocket expenses for eligible people if they receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a Delta Dental Premier Dentist.
- N. **Delta Dental PPO (Standard) (PPO Standard)** - means Delta Dental's national preferred provider organization that can reduce the out-of-pocket expenses for eligible people if they receive care from one of Delta Dental's PPO Dentists. See Your Summary of Dental Plan Benefits for further details.
- O. **Delta Dental Premier** - means Delta Dental's fee-for-service dental benefits discount program.
- P. **Deny/Denied/Denial** - When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.
- Q. **Dentist** - means a person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.
1. **Delta Dental PPO Dentist (Participating Dentist, In-Network Dentist)** means a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO. Our payment and your Coinsurance, if any, as payment in full for Covered Services.
  2. **Delta Dental Premier Dentist (Participating Dentist, In-Network Dentist)** means a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier. The fee schedules are different for PPO Dentists and Premier Dentists. Generally, Delta Dental pays the Dentist the agreed upon fee, based on the applicable fee schedule and the Dentist agrees to accept that amount as payment in full. However, as noted in the Claim Provisions, for the Standard PPO (Low) plan, Delta Dental pays Premier Dentists based on the PPO Fee Schedule and the individual is responsible for any difference between the PPO Fee Schedule and the Premier Fee Schedule for that Covered Service. Please see the example contained in the Summary of Dental Plan Benefits.

3. **Nonparticipating Dentist (Out-of-Network Dentist)** means a Dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.
4. **Out-of-Country Dentist (Out-of-Network Dentist)** means a Dentist whose office is located outside the United States and its territories.

Delta Dental PPO Dentists and Delta Dental Premier Dentists are sometimes referred to herein as **“In-Network Dentists or Participating Dentists.”** Wherever a definition or provision of this Policy differs from another state’s Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Nonparticipating Dentists and Out-of-Country Dentists are sometimes collectively referred to herein as **“Non-Participating Dentists” or “Out-of-Network Dentist.”**

**R. Eligible Dependent** – means:

1. Your Legal Spouse;
2. Your Children; or
3. Any other Children for whom you or your legal spouse are financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order; or
4. Any other dependents of yours who meet the criteria for eligibility set forth in the Summary of Dental Plan Benefits. If dependent coverage has been selected, it will be indicated in the Summary of Dental Plan Benefits. There is no limiting maximum age for an Eligible Dependent.

**S. Eligible Person** –the Insured or any Eligible Dependent.

**T. Emergency Services** – means those Covered Services that are required immediately to control bleeding, alleviate severe pain, get rid of acute infection, or otherwise avoid serious jeopardy to a persons health. Emergency services, services that are not of the type provided by any Delta Dental Participating Dentist, and services required to meet your health needs that are not reasonably available from a Delta Dental Participating Dentist without an unreasonable delay will be treated as if they had been provided by a Delta Dental PPO Dentist.

**U. Essential Health Benefits or EHB** – means those pediatric dental benefits set forth in the benchmark plan identified by the Federal Government, which currently is the MetLife Federal Dental Plan for 2014.

**V. In-Network Service**- means a Covered Service that is obtained from a Delta Dental PPO Dentist or Delta Dental Premier Dentist. Emergency Services, services that are not of the type provided by any Delta Dental Participating Dentist, and services required to meet your health needs that cannot be obtained from a Delta Dental Participating Dentist without an unreasonable delay will be treated as if they had been provided by a Delta Dental PPO Dentist.

**W. Insured** – means the person named in the application (sometimes referred to herein as “you” or “your”).

**X. Legal Spouse** - means a person who is any of the following: (a) the spouse of the Insured through a marriage legally recognized by the state in which this Policy was issued; or (b) the partner of the Insured through a civil union legally recognized by the state in which

this Policy was issued; or the Domestic Partner of the Insured (as defined in the Summary of Dental Plan Benefits), so long as any requirements listed in the Summary of Dental Plan Benefits are met and proof that those requirements are met is provided to Delta Dental at its request.

**Y. Maximum Approved Fee** -The Maximum Approved Fee means the lowest of:

- The Submitted Amount; or
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization; or
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty, based upon applicable Participating Dentist schedules and internal procedures.

Delta Dental PPO Dentists and Delta Dental Premier Dentists are not allowed to charge you more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for a Covered Service. The fee schedules are different for PPO Dentists and Premier Dentists. Generally, Delta Dental pays the Dentist the agreed upon fee, based on the applicable fee schedule and the Dentist agrees to accept that amount as payment in full. However, as noted in the "How the Payment Is Made" section of the Certificate, for the Standard PPO (Low) plan, Delta Dental pays Premier Dentists based on the PPO Fee Schedule and the individual is responsible for any difference between the PPO Fee Schedule and the Premier Fee Schedule for that Covered Service. Please see the example contained in the Summary of Dental Plan Benefits.

**Z. Maximum Payment** - means the maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the Maximum Payment applicable to this Policy.

**AA. Medically Necessary**- means that a dental item or service satisfies each of the following criteria as determined by Delta Dental's dental director: (a) is recommended by a Dentist or other qualified dental professional practicing within the scope of his or her license who has personally evaluated the patient; (b) is essential to and provided for prevention, evaluation, diagnosis or treatment of the patient's dental condition, disease or injury; (c) is consistent with the symptoms, finding and diagnosis related to the patient's dental condition, disease or injury; (d) is clinically appropriate for diagnosis and treatment of the patient's dental condition, disease or injury in terms of type, frequency, extent, site and duration of the intervention; (e) is considered to be an effective intervention for the patient's dental condition, disease or injury which can reasonably be expected to have beneficial health outcomes that outweigh potential harmful effects; (f) is performed in accordance with relevant credible scientific evidence and generally accepted professional standards of care; (g) is not experimental or investigational; (h) is required for reasons other than the convenience of the patient or treating provider; and (i) is not more costly than an item or alternative service that is at least as likely to produce equivalent diagnostic or therapeutic outcomes relative to patient's dental condition, disease or injury.

**BB. Nonparticipating Dentist Fee** - means the maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

**CC. Out-of-Country Dentist Fee** - means the maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

- DD. Out-of-Network Service** - means non-emergency, medically necessary Covered Service that is obtained from a Nonparticipating Dentist.
- EE. Out-of-Pocket Maximum** - means the maximum amount that you or your Eligible Dependent will pay for Covered Services during a Benefit Year as set forth in your Summary of Dental Plan Benefits.
- FF. Plan** - means the arrangement for the provision of Benefits to eligible people established by this Policy between Delta Dental and the Insured.
- GG. Policy** - means this document, issued and delivered to the Insured. It includes the attached pages, the application, the Summary of Dental Plan Benefits, and any attached amendments.
- HH. Post Service Claims** - means Claims for Benefits that are not conditioned on You seeking advance approval, certification, or authorization to receive the full amount of any Covered Service. In other words, Post Service Claims arise when the Eligible Person receives the dental service or treatment before the Claim is filed for the Benefits.
- II. PPO Dentist Schedule** - means the maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.
- JJ. Premier Dentist Schedule** - means the maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan
- KK. Pre-Treatment Estimate**- means a voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.
- A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under this Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits on the date the notice is issued. It is not a guarantee of future dental benefits or payment.
- Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, this Plan's limitations and any other provisions, together with any additional information or changes to the dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.
- LL. Processing Policies** - means Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of claims. The Processing Policies may be amended from time to time.
- MM. Submitted Amount** - - means the amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge the covered individual for the difference between this amount and the amount Delta Dental approves for the treatment. The fee schedules are different for PPO Dentists and Premier Dentists. Generally, Delta Dental pays the Dentist the agreed upon fee, based on the applicable fee schedule and the Dentist agrees to accept that amount as payment in full. However, as noted in the "How the Payment Is Made" section of the Certificate, for the Standard PPO (Low) plan, Delta Dental pays Premier Dentists based on the PPO Fee Schedule and the individual is

responsible for any difference between the PPO Fee Schedule and the Premier Fee Schedule for that Covered Service. Please see the example contained in the Summary of Dental Plan Benefits.

**NN. Summary of Dental Plan Benefits** – means a description of the specific provisions of your dental coverage. The Summary of Dental Plan Benefits is, and should be read as, a part of this Policy, and supersedes any contrary provision of the Policy.

### INSURED PERSON'S ELIGIBILITY

The persons insured on the effective date of this Policy will be the Insured and Eligible Dependents named in the application that has been approved by Delta Dental. The Summary of Dental Plan Benefits will have specific information about this Policy's rules for dependent eligibility. This Policy will be classified as follows:

**Individual Plan – Insured only**  
**Individual plus legal spouse Plan – Insured and legal spouse only**  
**Individual and One Child Plan**  
**Individual and Two Children Plan**  
**Individual and Three or more Children Plan**  
**One Child Family Plan – Insured, legal spouse, and one Child**  
**Two Child Family Plan – Insured, legal spouse, and two Children**  
**Three or more Children Family Plan – Insured, legal spouse, and three or more Children**

### ADDING NEW ELIGIBLE PERSONS

**Adding a Spouse:** The Insured may add your Spouse to the Policy. Within 30 days, the Insured must submit the Individual Dental Application/Update form for Delta Dental approval and pay the added premium that is required. The adult will not be insured until Delta Dental (1) approves the application; and (2) gives written notice to you that the Policy is changed; and (3) receives the required premium.

The effective date of coverage will be on the written notice sent to you.

**Adding a Newborn, Adopted or Foster Child:** A Child born to, adopted or fostered by the Insured will be covered from the time of his or her birth, placement with the Insured for adoption, or placement in the foster home until the 31<sup>st</sup> day after its birth or placement for adoption. An adopted Child will be covered from the date of placement for adoption, regardless of when the adoption is finalized. A newborn, adopted or foster Child may continue as a Covered Person after 31 days. If you wish to continue coverage beyond the first 31 days for a newborn, adopted or foster Child, you must submit a Individual Dental Application/Update form for Delta Dental approval within 31 days of the Child's birth or placement and pay the increase in premium (if any). This must be done by the 31<sup>st</sup> day after the Child's birth or placement for adoption or placement in the foster home. If no additional premium is required to add the newborn Child, foster Child or adopted Child, there are no requirements for prior notification; however you should complete the Individual Dental Application/Update form to facilitate Covered Services.

Treatment for congenital or developmental malformations or anomalies for a newborn, adopted, or fostered Child added as an Eligible Person as indicated above will be considered Covered Services, and will be covered at the appropriate level based on the class of benefits as shown in the General Benefit Provisions section below.

**Adding a Child Under Guardianship:** A Child for whom you or your legal spouse is a court-appointed guardian will be covered from the date of the filing of the application for appointment of guardianship with a court of competent jurisdiction, subject to the terms of the Policy, until the 31<sup>st</sup> day after that date, unless the guardianship is disrupted prior to the date the court appoints you or your Legal Spouse as guardian and the Child is removed from your or your legal spouse's physical custody. The Child may continue as an Eligible Dependent after the 31<sup>st</sup> day only if Delta Dental has received both written notice of the Child's pending guardianship status and any additional premium required.

**Adding Other Eligible Children:** To add any other Child as an Eligible Dependent, You must: (1) submit an application for Delta Dental approval; and (2) pay the additional premium (if any). The Child will not become an Eligible Dependent until Delta Dental (1) approves the application; (2) gives written notice to You that the Policy is changed, and (3) receives the required premium. The effective date of coverage will be in the written notice sent to you.

### SELECTING A DENTIST

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

This Policy provides for reasonable access to Delta Dental Participating Dentists. If there is not a general In-Network Dentist within thirty (30) or a specialty In-Network Dentist with sixty (60) miles of your home or workplace, Covered Services from a Nonparticipating Dentist will be paid at the Delta Dental PPO Dentist benefit level. If you feel that this may be the case, please call Delta Dental's Customer Service Department, toll-free, at 800-971-4108 or write them at P.O. Box 1596, Indianapolis, Indiana, 46206. When writing, please enclose a copy of your explanation of benefits, if applicable and describe the situation. Be sure to include your name, telephone number, the date and any information you would like considered about your Claim. We will review your situation and, if appropriate, approve payment for a Nonparticipating Dentist at the Delta Dental PPO Dentist benefit level.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at [www.deltadentalinc.com](http://www.deltadentalinc.com) or call (800) 971-4108.

### PRE-EXISTING CONDITIONS AND NONDISCRIMINATION

No person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex, or sexual orientation.

### ACCESSING YOUR BENEFITS

To utilize the coverage under your policy, follow these steps:

Please read this Policy and the Summary of Dental Plan Benefits carefully so you are familiar with the Benefits, payment methods, and terms of your Policy.

Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with your coverage or has questions about the Policy, have him or her contact Delta Dental by (a) writing Delta Dental, Attention: Customer Service, P.O. Box 1596, Indianapolis, Indiana, 46206, or (b) calling the toll-free number 1-800-971-4108

**Notice of Claim:** After you receive your dental treatment, you or the dental office staff will file a Claim form with Delta Dental or an agent authorized by Delta Dental within the required timeframe, completing the information portion with:

1. The Insured's full name and address

2. The Insured's Social Security number
3. The name and date of birth of the person receiving dental care
4. The Policy number

Your submission of a Claim form in accordance with this provision (or by submitting information to any agent authorized by Delta Dental sufficient to identify you as the insured), shall be deemed notice to Delta Dental.

**Claim Forms:** Delta Dental does not require special Claim forms. However, most dental offices have claim forms available. Participating Dentist offices will fill out and file claim forms for you. You may have to submit your own claim form if you receive treatment from a Nonparticipating Dentist. Claim forms are available at Delta Dental's website, [www.deltadentalnc.com](http://www.deltadentalnc.com) or you can call Customer Service at 1-800-971-4108 to request one.

Delta Dental, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

Claims and completed information requests should be mailed to:

**Delta Dental**  
P.O. Box 1596  
Indianapolis, Indiana, 46206

**Proof of Loss:** Written proof of loss must be filed with Delta Dental within 180 days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any Claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the case of legal incapacity of the Insured, later than one year from the time the proof is otherwise required.

**Pre-Treatment Estimate:** A Pre-Treatment Estimate is not required to receive payment, but it allows claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under this Policy are post-service Claims.

**Written Notice of Claim and Time of Payment:** We shall, within 30 calendar days after receipt of a Claim, send by electronic or paper mail to the claimant:

1. Payment of the Claim.
2. Notice of Denial of the Claim or fees not chargeable to the patient.
3. Notice that the proof of loss is inadequate or incomplete.
4. Notice that the Claim has not been submitted on the form required by Delta Dental.
5. Notice that coordination of benefits information is needed in order to pay the Claim.



6. Notice that the Claim is pending based on nonpayment of fees or premiums.

If a Claim is Denied, Delta Dental will provide complete details regarding the Denial. If Delta Dental requests additional information and does not receive the additional information within 90 days after the request is made, Delta Dental shall Deny the Claim and send the notice of Denial to the claimant.

Claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the Claim should have been paid. If additional information was requested by Delta Dental, interest on Claim payments shall begin to accrue on the 31st day after additional information is received by Delta Dental.

You may also appoint an authorized representative to deal with us on your behalf with respect to any benefit Claim you file or any review of a Denied Claim you wish to pursue (see the Reconsideration and Claims Appeal Procedure section). You should call Delta Dental's Customer Service department, toll-free, at 1-800-971-4108, or write them at P.O. Box 1596, Indianapolis, Indiana, 46206, to request a form to fill out designating the person you wish to appoint as your representative. While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate with you directly.

If you have any questions about your Policy, please call Delta Dental's Customer Service department, toll-free, at 1-800-971-4108. You may also write to Delta Dental's Customer Service department at P.O. Box 1596, Indianapolis, Indiana, 46206. When writing to Delta Dental, please include your name, the Policy number, the Insured's Member ID number, and your daytime telephone number.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or e-mail:

North Carolina Department of Insurance  
Consumer Services  
1201 Mail Service Center  
Raleigh, NC 27699-1202  
Consumer Hotline: (855) 408-1212

You can file a complaint electronically at [www.ncdoi.com](http://www.ncdoi.com)

**Payment of Claims:** Any accrued payments owed the Insured that are unpaid at the Insured's death will be made to the Insured's beneficiary or the Insured's estate, at the option of Delta Dental.

#### RENEWABILITY AND TERMINATION OF POLICY

**TERMINATION AND CONDITIONALLY RENEWABLE - PREMIUM MAY CHANGE:** We shall renew or continue in force the Policy at your option. You may keep the Policy in force by timely payment of the premiums. However, Delta Dental may refuse renewal due to:

A. Non-payment of premiums, subject to the Grace Period defined in this Policy; or

- B. We rescind coverage based upon fraud or intentional misrepresentation made by or with the knowledge of the Insured or a Eligible Dependent applying for this coverage (but for only two years following the later of the Effective Date or reinstatement date of the Policy) or when filing a Claim for Benefits; or
- C. Our ceasing to renew all Policies issued on this form to residents of the state where you live; or
- D. Written request received from you to terminate the Policy; or
- E. Your failure to reside or live in the state in which this Policy was issued; or
- F. Your death, if the Policy only covers you on the date of your death.

At least 30 days' notice of any non-renewal action or termination permitted by this clause will be mailed to you at your last address as shown in Delta Dental's records. This notice will identify the date upon which coverage under the Policy will cease. If Delta Dental fails to provide 30 days' notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid, subject to the Grace Period provisions.

If coverage is terminated under subsection (C) above, additional notice prior to termination will be provided. During the first year coverage is in force under the Policy, or during the first year following any lapse and reinstatement of the Policy, a period of 30 days' notice will be provided before the termination date. After one continuous year of coverage under the Policy and acceptance of premium for any portion of the second or subsequent year, the notice period will be the number of full months most nearly equivalent to one fourth the number of continuous months the Policy has been in effect from the inception date of the Policy to the date of mailing of the notice: Provided no period of required notice shall exceed two years.

We will refund any premium paid and not earned due to Policy termination.

If this Policy covers other Eligible Dependents on the date of your death it may be continued after Your death: (a) by Your Legal Spouse, if an Eligible Dependent; otherwise, (b) by the youngest Child who is an Eligible Dependent (if Children are covered under this Policy). The Policy will be changed to a plan appropriate, as determined by Delta Dental, to the Eligible Dependents who continue to be covered under it. Your Legal Spouse, or youngest Child, will replace you as the Insured. A proper adjustment will be made in the premium required for the Policy to be continued. We will also refund any premium paid and not earned due to your death.

**Termination of Legal Spouse's Coverage:** The Insured's Legal Spouse will cease to be an Eligible Dependent at the end of the premium period in which you become legally divorced.

**Termination of a Child's Coverage:** A Child will cease to be covered under this Policy at the time he or she ceases to meet the definition of an Eligible Dependent. .

**Benefits After Coverage Terminates:** Termination of coverage will be without prejudice to any Claim for Covered Services incurred prior to the date coverage terminates. Benefits for Covered Services incurred after an Eligible Dependent ceases to be insured are provided for certain procedures. No Benefits are provided, however, if the Policy is terminated because of: (a) a request by the Insured; (b) fraud or material misrepresentation on your part during the first two years following the later of the Effective date or reinstatement date of the Policy; or (c) your failure to pay premiums subject to the Grace Period. Certain procedures begun before the coverage terminates may be covered if the services were completed within a 30-day period measured from the date of termination. In those cases, Delta Dental will evaluate those services

in progress to determine what portion may be paid by Delta Dental. The balance of the total fee is your responsibility.

## GENERAL BENEFIT PROVISIONS

### Types of Dental Benefits

Delta Dental agrees to provide Benefits to the eligible people under the policies and procedures of Delta Dental, including the Processing Policies, and under the terms and conditions of this Policy, including, but not limited to, the following categories, exclusions, and limitations.

Please note that certain Covered Services provided to individuals age 18 and under are considered Essential Health Benefits and are subject to specific rules concerning applicable Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations. For a complete list of those services designated as Essential Health Benefits, as well as the applicable rules governing Essential Health Benefits, please see your Summary of Dental Plan Benefits. In the event an individual age 18 and under receives a Covered Service designated as an Essential Health Benefit, the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Summary of Dental Plan Benefits shall be controlling. In no event will the general frequency limitations set forth in this Policy apply to any of the Covered Services listed as Essential Health Benefits in your Summary of Dental Plan Benefits. The remaining general exclusions and limitations found in this Policy shall only apply to a Covered Service designated as an Essential Health Benefit to the extent those general exclusions and limitations do not conflict with the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Summary of Dental Plan Benefits.

The Benefits covered by this Policy are set forth in your Summary of Dental Plan Benefits.

### REDUCTIONS

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 applicable prior dates of services in our records:

1. Bitewing X-rays are payable twice per calendar year for individuals age 18 and under and once per calendar year for individuals 19 years of age or older.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are limited to once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are limited to twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral exams or evaluations are 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 individuals age 18 and under.

7. Space maintainers for posterior teeth are payable for people age 18 and under. A distal shoe space maintainer is only payable for first permanent molars.
8. 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.
9. Sealants are limited to once per tooth per three-year period on unrestored permanent molars for individuals age 18 and under.
10. Preventative resin restorations are limited to once per tooth per three-year period on permanent teeth for a moderate to high carries risk patient.
11. Prefabricated stainless steel crowns are limited to once per tooth per five-year period.
12. Crowns, onlays and associated procedures (such as core buildups and post substructures) are limited to once in any five-year period per tooth.
13. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) and/or fracture (lost or mobile tooth structure).
14. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.
15. An occlusal guard is payable once in a lifetime for individuals 19 years of age or older.
16. For individuals age 18 and under, benefits for an interim partial denture are limited to situations involving the replacement of permanent anterior teeth. For people 19 years of age or older, benefits for an interim partial denture are limited to situations involving the replacement of permanent anterior teeth during the healing period.
17. Biological material to aid in soft and osseous tissue regeneration are payable once per tooth in a 36 month period.
18. Prosthodontic Services limitations:
  - a. One complete upper, one complete lower denture, and any implant used to support a denture are limited to 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 reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
  - d. Implant removal is payable once in any five-year period per tooth or area.
  - e. Implant maintenance is payable once per any twelve (12) month period.
  - f. Removal of a broken implant retaining screw is payable once in a 5 year period.
19. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
  - a. Orthodontic Services are payable for individuals age 18 and under in situations deemed medically necessary.

- 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.
  - d. Benefits for an observation and adjustment are limited to twice in a 12-month period.
20. 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.
21. 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.
22. Care terminated due to the death of an individual will be paid to the limit of Delta Dental's liability for the services completed or in progress.
23. Prefabricated crowns used as final restorations on permanent teeth are limited to individuals age 18 and under.
24. Metal bases on removable prostheses are limited to individuals age 18 and under.
25. Radiographic/surgical implant index are limited to individuals age 18 and under.
26. Diagnostic photographs and cephalometric films are limited to individuals age 18 and under unless such services were performed in conjunction with Orthodontic Services and orthodontics are a Covered Service.
27. 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, 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 for 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 for the amount that it would pay for a conventional fixed bridge.
- f. Implant/abutment supported complete or partial dentures –Delta Dental will pay only for the amount that it would pay for a conventional denture.
- g. Gold foil restorations –Delta Dental will pay only for 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 for the amount that it would pay for a conventional stainless steel crown.

28. Maximum Payment:

- a. All Benefits payable under This Plan are subject to the Maximum Payment limitations stated in your Summary of Dental Plan Benefits.
- b. Delta Dental's payment for Orthodontic Services will be limited to the annual or lifetime Maximum Payment stated in your Summary of Dental Plan Benefits.

29. 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.

30. Processing Policies may otherwise limit by Delta Dental payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. However, Participating Dentists may not charge eligible people for these services or supplies when performed by the same Dentist or dental office. All charges from Nonparticipating Dentists for services that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records.

1. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures.
2. Root planing is limited to once in any two-year period.
3. Periodontal surgery is limited to once in any three-year period.
4. 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.
5. One caries risk assessment is allowed on the same date of service.
6. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office.
7. 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 for individuals 19 years of age or older. All such charges are your responsibility. However, Participating Dentists may not charge any individual, regardless of age, for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records:

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. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
3. Retention pins are payable once in a two-year period. Only one substructure per tooth is a Covered Service.
4. Tissue conditioning is payable twice per arch in any three-year period.
5. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
6. Processing Policies may otherwise limit payment by Delta Dental for services or supplies.

#### **EXCEPTIONS**

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

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, for individuals 19 years of age or older. This exclusion does not apply to any newborn, adopted or foster child who becomes covered under this Policy after the effective date.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental. This exclusion does not apply to any newborn, adopted or foster child who becomes covered under this Policy after the effective date.
4. Services completed or appliances completed before a person became eligible under this Policy. 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 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 dental professional, may be covered only as solely determined by 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 not within the categories of Benefits that have been selected and that are not covered under the terms of the Policy.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Interim caries arresting medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Sealants, for individuals 19 years of age or older.
21. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
22. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
23. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position. This exclusion does not apply to any newborn, adopted or foster child who becomes covered under this Policy after the effective date.
24. Veneers.
25. Prefabricated crowns used as final restorations on permanent teeth.
26. 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 Policy.
27. Implant/abutment supported interim fixed denture for edentulous arch.
28. Paste-type root canal fillings on permanent teeth, for individuals 19 years of age or older.
29. Replacement, repair, relines, or adjustments of occlusal guards, for individuals 19 years of age or older.
30. Chemical curettage, for individuals 19 years of age or older.
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, for individuals 19 years of age or older.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as soft tissue grafting, guided tissue regeneration 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 (TMJ).
41. Diagnostic photographs and cephalometric films, for individuals 19 years of age or older, unless done for Orthodontics and Orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses, for individuals 19 years of age or older.
44. Any and all taxes applicable to the services.
45. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services. Participating Dentists may not charge Members for these services. All charges from Nonparticipating 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. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups.
15. Any substructure when done for inlays, onlays, and veneers.
16. 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.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
  1. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
  2. 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.
  3. Full mouth debridement when done within 30 days of scaling and root planing.
  4. 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.
  5. Full mouth debridement, when done on the same day as a comprehensive evaluation.
26. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
27. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
28. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
29. 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.
30. Teledentistry fees.

31. Processing policies may otherwise exclude payment by Delta Dental for services or supplies

## CLAIM PROVISIONS

### Agreement

Delta Dental agrees to make payments for Covered Services provided to the Insured and Eligible Dependents as described below and on the Summary of Dental Plan Benefits. The Plan that is chosen by the Insured and specified on the Summary of Dental Plan Benefits will determine how payment is made.

### Payment of Claims

Your Summary of Dental Plan Benefits will indicate whether the Plan you have selected is Delta Dental PPO (Standard) or Delta Dental PPO (Plus Premier) and will also set forth your applicable Coinsurance. Remember, your actual out-of-pocket cost may be more if you receive treatment from a Nonparticipating Dentist.

#### A. Delta Dental PPO (Standard):

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule. Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

If your Dentist is not a Delta Dental PPO Dentist, but is a Delta Dental Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Coinsurance, Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

#### B. Delta Dental PPO (Plus Premier):

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Coinsurance, Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to

the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

### **Orthodontics**

Medically necessary orthodontics will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Medically necessary orthodontic procedures require a pre-treatment evaluation for coverage under this Policy. Orthodontic services are only covered benefits under this Policy when the patient's condition meets the State of North Carolina criteria for coverage of orthodontics, i.e., severe malocclusions caused by craniofacial anomalies like cleft lip and palate or other conditions caused by a syndrome that affect their daily ability to function, like eating and speaking.

### **Covered Services Requiring Multiple Visits**

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

### **Informal Claims Appeal Procedure**

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your Claim is filed. An adverse benefit determination is any Denial, reduction, or termination of the Benefit for which you filed a Claim, or a failure to provide or to make payment (in whole or in part) of the Benefit you sought ("Adverse Benefit Determination").

This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

If Delta Dental informs you that the Policy will pay the Benefit you sought but will not pay the total amount of expenses incurred, and you must make a payment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination and you think that Delta Dental incorrectly Denied all or part of your Claim, you can take the following steps. First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, 1-800-971-4108, and ask them to reconsider the Claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 1596, Indianapolis, Indiana 46206.

When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your Claim. This inquiry 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 and submit information that might indicate that your Claim was improperly Denied and allow Delta Dental to correct this error quickly.

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.

Whether or not you have asked Delta Dental informally, as described above, to reconsider its initial determination, you can submit your Claim to a formal review through 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, MI 48909-7916**

Please include your name and address, the Insured's Member ID number, the reason you believe your claim was wrongly Denied, any other information you believe supports your Claim, and indicate in your letter that you are requesting a formal appeal of your Claim. You also have the right to review any documents related to the Policy. If you would like a record of your request and proof that Delta Dental received it, you should mail it 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 Dental Director will make a decision within 30 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.

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the Denial, the pertinent Policy 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 Disputed Claims 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.

If you are still not satisfied, you may contact the North Carolina Department of Insurance for instructions on filing a consumer complaint by calling (855) 408-1212 or (919) 807-6750. You may also write to the Consumer Services Division of the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1202, or visit the Department's website at <http://www.ncdoi.com>.

## GENERAL PROVISIONS

- A. Entire Contract; Changes:** This Policy, which includes the attached pages, the application, the Summary of Dental Plan Benefits, and any attached amendments, constitutes the entire contract between the parties hereto. No changes in this Policy will be effective until Delta Dental approves them in writing. No agent may change this Policy or waive any of its provisions.
- B. Time Limit on Certain Defenses:** After two years from the date coverage is effective under this Policy or under its reinstatement, if applicable, no misstatements, made by the applicant in any application for such Policy shall be used to void this Policy or to Deny a Claim for loss incurred after the expiration of such two year period.
- C. Reinstatement:** If you do not pay the premium by the end of the Grace Period, your Policy will lapse. This Policy may be reinstated, but Delta Dental may require an application. You must also pay the premium to Delta Dental.

If an application is not required, your Policy will be reinstated when the premium is accepted. If an application is required, and a conditional receipt is issued, your Policy will be reinstated when the application is approved by Delta Dental. If the application is disapproved, your Policy will not be reinstated. If the application is received by Delta Dental, but is neither disapproved in writing nor approved, your Policy will be reinstated 45 days after the date of the conditional receipt.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

A change may be made in your Policy in connection with the reinstatement. These changes will be sent to you for you to attach to your Policy. In all other respects, you and Delta Dental will have the same rights as before your Policy lapsed.

- D. Physical Examination and Autopsy:** Delta Dental, at its own expense, shall have the right and opportunity to examine the insured when and as often as it may reasonably require during the pendency of a Claim hereunder.
- E. Legal Actions:** No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless prohibited by applicable state law. No such action may be brought after the expiration of the applicable statute of limitations (three years in North Carolina) from the time written proof of loss is required to be given.
- F. Change of Beneficiary:** Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of the

beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

- G. Misstatement of Age:** If you or your Eligible Dependent's age has been misstated, and the age was a factor in determining the premium, the Benefits may be adjusted, based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.
- H. Conformity With State Laws:** Any part of the Policy in conflict with the laws of the state where you live on the Policy's Effective Date is changed to conform to the minimum requirements of that state's laws.
- I. Change of Status:** You must notify Delta Dental of any event that changes the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.
- J. Assignment:** Services and/or benefit payments are for the personal benefit of you and your Eligible Dependent(s) cannot be transferred or assigned, other than to the extent necessary to allow direct payments to Participating Dentists.
- K. Obtaining and Releasing Information:** While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your claims and administer Benefits. . This includes allowing Delta Dental to have access to your dental records.
- L. Dentist-Patient Relationship:** Individuals are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided, and Delta Dental does not have any liability resulting therefrom.
- M. Right of Recovery Due to Fraud:** If Delta Dental pays for dental services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to the acts of you and/or your Eligible Dependent, it may recover that payment from you and/or your Eligible Dependent within twelve (12) months from the date the claim was paid. You and/or your Eligible Dependent authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you and/or your Eligible Dependent. Not less than 30 calendar days before we seek overpayment recovery or offset future payments, we will provide a written notice to the Dentist containing adequate information to identify the specific claim and reason(s) for the recovery . This action may be taken in the first two years after the date the original claim was paid.



### IMPORTANT DISCLOSURE

From time to time, we may offer or provide you certain goods and services, including discounts on dental services provided by Dentists in addition to the dental coverage (including without limitation toothbrushes, dental floss and other oral hygienic devices/products). We also may arrange for third party vendors to provide goods and services at a discount to you. Though we may make the arrangements, the third party vendors are solely liable for providing the goods and services. We shall not be responsible for providing or failing to provide the goods and services to you. Further, we shall not be

liable to You for negligent provision of the goods and services by third party vendors. We reserve the right to terminate or change these goods or services at any time.

## PREMIUMS

**Premium Payment:** Each premium is to be paid on or before its due date, subject to the Grace Period. A due date is the last day of the period for which the preceding premium was paid. Premium is to be paid annually. Delta Dental will also accept monthly premiums only when paid by credit card or automatic withdrawal, or when paid with our prior consent.

From time to time, but no more than once every 12 months, Delta Dental may change the rate tables used for this Policy form. Each premium will be based on the rate table in effect on that premium's due date. The Policy plan, age, and sex of Insured, length of time the Policy has been in force, and place of residence on the premium due date are factors used in determining premium rates. Delta Dental will make no change in your premium solely because of claims made under this Policy.

Premium changes will be applicable to all Insureds under this Policy form in the state of North Carolina at one time, and will not change more frequently than once in any 12 month period. At least 45 days' notice of any rate change as permitted by this clause, will be mailed to you at Your last address as shown in Our records.

**Grace Period:** This Policy has a 31-day grace period (the "Grace Period"). This means that if a premium, other than the initial premium, is not paid by the date it is due, it may be paid during the following 31 days. Your Policy will remain in force during this Grace Period. The Grace Period will not apply if, at least 30 days before the due date, Delta Dental has delivered or mailed to your last known address a written notice of our intent not to renew this Policy.

Para asistencia en español, llame al número de servicio al cliente (customer service) que aparece en el reverso de su tarjeta para miembros.

This document is also available in alternative formats upon request and at no cost to persons with disabilities.

**Inquiries**  
**Delta Dental**  
**Attention: Customer Service**  
**P.O. Box 1596**  
**Indianapolis, Indiana, 46206**  
**Customer Service: (800) 971-4108 (TTY users call 711)**