



### **THINGS TO REMEMBER**

- Be sure to check participating dentists, as some may have changed.
- Visit [www.deltadentalins.com](http://www.deltadentalins.com) to search for providers for each plan.
- When choosing a network, for PPO Copay & PPO Plus, choose "Delta Dental PPO". Choose "Delta Dental Premier" for the PPO Premier Plan.
- Always contact the specific dental office to ensure they are accepting new patients.

# Freedom to choose, easy to use

## Delta Dental PPO™ Copay Plan



It's not always easy to meet in the middle, but it doesn't have to feel like a compromise when it comes to dental benefits.

Delta Dental<sup>1</sup> has an affordable option that offers the best features of our two most popular plans. With a Delta Dental PPO<sup>1</sup> copay plan, enrollees can enjoy the simplicity of a copayment plan with the freedom of dentist choice that a PPO plan offers.

And, you won't have to compromise your budget or your enrollees' wallets either.

Choose the right fit for your organization from fully insured or self-funded and a range of contribution options from voluntary to employer-paid.

### How it works

The Delta Dental PPO copay plan allows enrollees to use their benefits at any licensed dentist, but coverage works differently when enrollees visit a PPO network dentist versus a non-PPO dentist.

**Inside the PPO network:** The plan has copayments for each covered procedure, so enrollees know exactly what they owe the dentist.

**Outside the PPO network:** The plan pays a percentage of the contract allowance for covered procedures and the enrollee pays the remaining share, called coinsurance.

Review the chart for examples of some common procedures.

| Sample Covered Services <sup>2</sup>                                   | Delta Dental PPO dentist      | Non-PPO dentist<br>(Delta Dental Premier <sup>®</sup> and non Delta Dental)                 |
|--|-------------------------------|---|
|  | Enrollee pays copayment shown | Plan pays coinsurance percentage of contract allowance shown below; enrollee pays remainder |
| D1110 - Prophylaxis ( <i>cleaning</i> ) — adult                        | No cost                       | 50%   |
| D2330 - Resin ( <i>tooth-colored</i> ) filling, front tooth, 1 surface | \$20.92                       | 40%   |
| D2750 - Crown, porcelain <i>and precious metal</i>                     | \$422.41                      | 25%   |

After enrollment, enrollees are provided a full list of covered procedures with their copayments and allowances, so there's no confusion about what is and isn't a plan benefit.



## Ways to save

Enrollees usually save the most money when they visit a PPO dentist. These dentists have agreed to discounted fees for covered services.

Enrollees may have moderate savings with a Delta Dental Premier dentist. These dentists, though out-of-network, have a limit to what they can charge.

Dentists not contracted with Delta Dental have no limit to what they can charge and can bill up to their full fee.

Delta Dental Insurance Company  
1130 Sanctuary Parkway  
Alpharetta, GA 30009  
800-521-2651

## More plan features<sup>3</sup>

- » No waiting periods
- » No deductibles in-network
- » No maximums in-network
- » Routine care in-network at low or no cost

<sup>1</sup> Delta Dental PPO is underwritten in Florida by Delta Dental Insurance Company.

<sup>2</sup> Procedure codes and descriptions (Current Dental Terminology - CDT) are copyrighted by the American Dental Association. Text that appears in italics was added to clarify the services listed and is not part of CDT procedure code descriptions.

<sup>3</sup> This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please consult the plan contract for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the plan contract, the terms of the contract will prevail. For more information, costs and complete details of the coverage, please contact your benefit administrator.

## Delta Dental PPO™ Copay Plan

| Class    | CDT Code | Description  | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|----------|----------|--|------------------------|---------------------------------|
| Class I  | D0120    | Periodic oral evaluation - established patient   | \$0.00                 | 50.00%                          |
| Class I  | D0140    | Limited oral evaluation - problem focused  | \$0.00                 | 50.00%                          |
| Class I  | D0145    | Oral evaluation for a patient under three years of age and counseling with primary caregiver | \$0.00                 | 50.00%                          |
| Class I  | D0150    | Comprehensive oral evaluation - new or established patient                                   | \$0.00                 | 50.00%                          |
| Class I  | D0160    | Detailed and extensive oral evaluation - problem focused, by report                          | \$0.00                 | 50.00%                          |
| Class I  | D0170    | Re-evaluation - limited, problem focused (established patient; not post-operative visit)     | \$0.00                 | 50.00%                          |
| Class I  | D0180    | Comprehensive periodontal evaluation - new or established patient                            | \$0.00                 | 50.00%                          |
| Class I  | D0210    | Intraoral - complete series (including bitewings)  | \$0.00                 | 50.00%                          |
| Class I  | D0220    | Intraoral - periapical first film  | \$0.00                 | 50.00%                          |
| Class I  | D0230    | Intraoral - periapical each additional film  | \$0.00                 | 50.00%                          |
| Class I  | D0240    | Intraoral - occlusal film  | \$0.00                 | 50.00%                          |
| Class I  | D0250    | Extraoral - first film   | \$0.00                 | 50.00%                          |
| Class I  | D0260    | Extraoral - each additional film   | \$0.00                 | 50.00%                          |
| Class I  | D0270    | Bitewing <i>radiograph</i> - single film   | \$0.00                 | 50.00%                          |
| Class I  | D0272    | Bitewings <i>radiographs</i> - two films   | \$0.00                 | 50.00%                          |
| Class I  | D0273    | Bitewings <i>radiographs</i> -three films  | \$0.00                 | 50.00%                          |
| Class I  | D0274    | Bitewings <i>radiographs</i> - four films  | \$0.00                 | 50.00%                          |
| Class I  | D0277    | Vertical bitewings - 7 to 8 films  | \$0.00                 | 50.00%                          |
| Class I  | D0330    | Panoramic film   | \$0.00                 | 50.00%                          |
| Class I  | D0340    | Cephalometric radiographic image   | \$0.00                 | 50.00%                          |
| Class I  | D0350    | 2D oral/facial photographic image obtained intra-orally or extra-orally                      | \$0.00                 | 50.00%                          |
| Class I  | D0460    | Pulp vitality tests  | \$0.00                 | 50.00%                          |
| Class I  | D0470    | Diagnostic casts   | \$0.00                 | 50.00%                          |
| Class I  | D1110    | Prophylaxis <i>cleaning</i> - adult  | \$0.00                 | 50.00%                          |
| Class I  | D1120    | Prophylaxis <i>cleaning</i> - child  | \$0.00                 | 50.00%                          |
| Class I  | D1206    | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients  | \$0.00                 | 50.00%                          |
| Class I  | D1208    | Topical application of fluoride  | \$0.00                 | 50.00%                          |
| Class I  | D1351    | Sealant - per tooth  | \$0.00                 | 50.00%                          |
| Class II | D1510    | Space maintainer - fixed - unilateral  | \$48.80                | 40.00%                          |
| Class II | D1515    | Space maintainer - fixed - bilateral   | \$64.89                | 40.00%                          |
| Class II | D1520    | Space maintainer - removable - unilateral  | \$62.68                | 40.00%                          |
| Class II | D1525    | Space maintainer - removable - bilateral   | \$87.01                | 40.00%                          |
| Class II | D1550    | Recementation of space maintainer  | \$10.88                | 40.00%                          |
| Class II | D2140    | Amalgam - one surface, primary or permanent  | \$21.49                | 40.00%                          |
| Class II | D2150    | Amalgam - two surfaces, primary or permanent   | \$27.03                | 40.00%                          |
| Class II | D2160    | Amalgam - three surfaces, primary or permanent   | \$31.97                | 40.00%                          |

| Class     | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|-----------|----------|---|------------------------|---------------------------------|
| Class II  | D2161    | Amalgam - four or more surfaces, primary or permanent                               | \$39.89                | 40.00%                          |
| Class II  | D2330    | Resin-based composite - one surface, anterior (tooth colored)                       | \$20.92                | 40.00%                          |
| Class II  | D2331    | Resin-based composite - two surfaces, anterior (tooth colored)                      | \$27.84                | 40.00%                          |
| Class II  | D2332    | Resin-based composite - three surfaces, anterior (tooth colored)                    | \$34.55                | 40.00%                          |
| Class II  | D2335    | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | \$40.59                | 40.00%                          |
| Class II  | D2390    | Resin-based composite crown, anterior   | \$45.46                | 40.00%                          |
| Class II  | D2391    | Resin-based composite - one surface, posterior                                      | \$23.64                | 40.00%                          |
| Class II  | D2392    | Resin-based composite - two surfaces, posterior                                     | \$33.21                | 40.00%                          |
| Class II  | D2393    | Resin-based composite - three surfaces, posterior                                   | \$40.79                | 40.00%                          |
| Class II  | D2394    | Resin-based composite - four or more surfaces, posterior                            | \$46.30                | 40.00%                          |
| Class II  | D4341    | Periodontal scaling and root planing, four or more teeth per quadrant               | \$35.70                | 40.00%                          |
| Class II  | D4342    | Periodontal scaling and root planing, one to three teeth, per quadrant              | \$18.74                | 40.00%                          |
| Class II  | D4355    | Full mouth debridement to enable comprehensive evaluation and diagnosis             | \$24.07                | 40.00%                          |
| Class II  | D4910    | Periodontal maintenance   | \$21.03                | 40.00%                          |
| Class II  | D7111    | Extraction, coronal remnants - deciduous teeth                                      | \$19.31                | 40.00%                          |
| Class II  | D7140    | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)        | \$24.31                | 40.00%                          |
| Class III | D2510    | Inlay - metallic - one surface  | \$273.03               | 25.00%                          |
| Class III | D2520    | Inlay - metallic - two surfaces   | \$343.77               | 25.00%                          |
| Class III | D2530    | Inlay - metallic - three or more surfaces   | \$377.55               | 25.00%                          |
| Class III | D2542    | Onlay - metallic - two surfaces   | \$386.01               | 25.00%                          |
| Class III | D2543    | Onlay - metallic - three surfaces   | \$379.24               | 25.00%                          |
| Class III | D2544    | Onlay - metallic - four or more surfaces  | \$391.33               | 25.00%                          |
| Class III | D2610    | Inlay - porcelain/ceramic - one surface   | \$321.30               | 25.00%                          |
| Class III | D2620    | Inlay - porcelain/ceramic - two surfaces  | \$376.33               | 25.00%                          |
| Class III | D2630    | Inlay - porcelain/ceramic - three or more surfaces                                  | \$381.32               | 25.00%                          |
| Class III | D2642    | Onlay - porcelain/ceramic - two surfaces  | \$387.05               | 25.00%                          |
| Class III | D2643    | Onlay - porcelain/ceramic - three surfaces  | \$391.83               | 25.00%                          |
| Class III | D2644    | Onlay - porcelain/ceramic - four or more surfaces                                   | \$412.54               | 25.00%                          |
| Class III | D2650    | Inlay - resin-based composite - one surface   | \$214.90               | 25.00%                          |
| Class III | D2651    | Inlay - resin-based composite - two surfaces  | \$272.63               | 25.00%                          |
| Class III | D2652    | Inlay - resin-based composite - three or more surfaces                              | \$255.28               | 25.00%                          |
| Class III | D2662    | Onlay - resin-based composite - two surfaces  | \$248.04               | 25.00%                          |
| Class III | D2663    | Onlay - resin-based composite - three surfaces                                      | \$291.80               | 25.00%                          |
| Class III | D2664    | Onlay - resin-based composite - four or more surfaces                               | \$286.48               | 25.00%                          |
| Class III | D2710    | Crown - resin-based composite (indirect)  | \$163.91               | 25.00%                          |

| Class     | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|-----------|----------|---|------------------------|---------------------------------|
| Class III | D2720    | Crown - resin with high noble metal   | \$424.03               | 25.00%                          |
| Class III | D2721    | Crown - resin with predominantly base metal   | \$379.83               | 25.00%                          |
| Class III | D2722    | Crown - resin with noble metal  | \$406.25               | 25.00%                          |
| Class III | D2740    | Crown - porcelain/ceramic substrate   | \$430.58               | 25.00%                          |
| Class III | D2750    | Crown - porcelain fused to high noble metal   | \$422.41               | 25.00%                          |
| Class III | D2751    | Crown - porcelain fused to predominantly base metal   | \$386.02               | 25.00%                          |
| Class III | D2752    | Crown - porcelain fused to noble metal  | \$392.65               | 25.00%                          |
| Class III | D2790    | Crown - full cast high noble metal  | \$437.46               | 25.00%                          |
| Class III | D2791    | Crown - full cast predominantly base metal  | \$387.76               | 25.00%                          |
| Class III | D2792    | Crown - full cast noble metal   | \$387.94               | 25.00%                          |
| Class III | D2910    | Recement inlay, onlay or partial coverage restoration   | \$38.63                | 25.00%                          |
| Class III | D2920    | Recement crown  | \$37.96                | 25.00%                          |
| Class III | D2930    | Prefabricated stainless steel crown - primary tooth   | \$109.21               | 25.00%                          |
| Class III | D2931    | Prefabricated stainless steel crown - permanent tooth   | \$125.20               | 25.00%                          |
| Class III | D2932    | Prefabricated resin crown - anterior primary tooth  | \$125.58               | 25.00%                          |
| Class III | D2940    | Protective restoration  | \$42.37                | 25.00%                          |
| Class III | D2950    | <i>Core buildup, including any pins</i>   | \$103.18               | 25.00%                          |
| Class III | D2951    | Pin retention - per tooth, in addition to restoration   | \$21.52                | 25.00%                          |
| Class III | D2952    | Post and core in addition to crown, indirectly fabricated   | \$160.21               | 25.00%                          |
| Class III | D2954    | Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>                                       | \$129.56               | 25.00%                          |
| Class III | D3220    | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | \$61.56                | 25.00%                          |
| Class III | D3310    | Root canal - endodontic therapy - anterior tooth (excluding final restoration)  | \$303.70               | 25.00%                          |
| Class III | D3320    | Root canal - endodontic therapy - bicuspid tooth (excluding final restoration)  | \$341.88               | 25.00%                          |
| Class III | D3330    | Root canal - endodontic therapy - molar (excluding final restoration)   | \$464.62               | 25.00%                          |
| Class III | D3346    | Retreatment of previous root canal therapy - anterior   | \$357.52               | 25.00%                          |
| Class III | D3347    | Retreatment of previous root canal therapy - bicuspid   | \$432.53               | 25.00%                          |
| Class III | D3348    | Retreatment of previous root canal therapy - molar  | \$544.29               | 25.00%                          |
| Class III | D3410    | Apicoectomy/periradicular surgery - anterior  | \$293.42               | 25.00%                          |
| Class III | D3421    | Apicoectomy/periradicular surgery - bicuspid (first root)   | \$335.37               | 25.00%                          |
| Class III | D3425    | Apicoectomy/periradicular surgery - molar (first root)  | \$349.93               | 25.00%                          |
| Class III | D3426    | Apicoectomy/periradicular surgery (each additional root)  | \$126.75               | 25.00%                          |
| Class III | D3430    | Retrograde filling - per root   | \$94.64                | 25.00%                          |
| Class III | D4210    | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant  | \$301.00               | 25.00%                          |

| Class     | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|-----------|----------|---|------------------------|---------------------------------|
| Class III | D4211    | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant                              | \$131.97               | 25.00%                          |
| Class III | D4240    | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant            | \$359.17               | 25.00%                          |
| Class III | D4241    | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant            | \$186.74               | 25.00%                          |
| Class III | D4249    | Clinical crown lengthening - hard tissue  | \$361.00               | 25.00%                          |
| Class III | D4260    | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant         | \$553.00               | 25.00%                          |
| Class III | D4261    | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant         | \$292.43               | 25.00%                          |
| Class III | D5110    | Complete denture - maxillary  | \$592.10               | 25.00%                          |
| Class III | D5120    | Complete denture - mandibular   | \$592.10               | 25.00%                          |
| Class III | D5130    | Immediate denture - maxillary   | \$645.42               | 25.00%                          |
| Class III | D5140    | Immediate denture - mandibular  | \$645.42               | 25.00%                          |
| Class III | D5211    | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)                                     | \$536.87               | 25.00%                          |
| Class III | D5212    | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)                                    | \$623.05               | 25.00%                          |
| Class III | D5213    | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  | \$657.40               | 25.00%                          |
| Class III | D5214    | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | \$657.40               | 25.00%                          |
| Class III | D5410    | Adjust complete denture - maxillary   | \$33.37                | 25.00%                          |
| Class III | D5411    | Adjust complete denture - mandibular  | \$33.37                | 25.00%                          |
| Class III | D5421    | Adjust partial denture - maxillary  | \$33.37                | 25.00%                          |
| Class III | D5422    | Adjust partial denture - mandibular   | \$33.37                | 25.00%                          |
| Class III | D5510    | Repair broken complete denture base   | \$66.67                | 25.00%                          |
| Class III | D5520    | Replace missing or broken teeth - complete denture (each tooth)   | \$56.22                | 25.00%                          |
| Class III | D5610    | Repair resin denture base   | \$71.63                | 25.00%                          |
| Class III | D5620    | Repair cast framework   | \$77.65                | 25.00%                          |
| Class III | D5630    | Repair or replace broken clasp  | \$93.70                | 25.00%                          |
| Class III | D5640    | Replace broken teeth - per tooth  | \$60.99                | 25.00%                          |
| Class III | D5650    | Add tooth to existing partial denture   | \$82.61                | 25.00%                          |
| Class III | D5660    | Add clasp to existing partial denture   | \$98.39                | 25.00%                          |
| Class III | D5710    | Rebase complete maxillary denture   | \$250.08               | 25.00%                          |
| Class III | D5711    | Rebase complete mandibular denture  | \$238.59               | 25.00%                          |
| Class III | D5720    | Rebase maxillary partial denture  | \$239.22               | 25.00%                          |
| Class III | D5721    | Rebase mandibular partial denture   | \$239.22               | 25.00%                          |

| Class     | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|-----------|----------|---|------------------------|---------------------------------|
| Class III | D5730    | Reline complete maxillary denture (chairside)                 | \$139.96               | 25.00%                          |
| Class III | D5731    | Reline complete mandibular denture (chairside)                | \$139.96               | 25.00%                          |
| Class III | D5740    | Reline maxillary partial denture (chairside)                  | \$126.40               | 25.00%                          |
| Class III | D5741    | Reline mandibular partial denture (chairside)                 | \$126.40               | 25.00%                          |
| Class III | D5750    | Reline complete maxillary denture (laboratory)                | \$182.45               | 25.00%                          |
| Class III | D5751    | Reline complete mandibular denture (laboratory)               | \$182.45               | 25.00%                          |
| Class III | D5760    | Reline maxillary partial denture (laboratory)                 | \$185.58               | 25.00%                          |
| Class III | D5761    | Reline mandibular partial denture (laboratory)                | \$185.58               | 25.00%                          |
| Class III | D5850    | Tissue conditioning, maxillary                                | \$59.49                | 25.00%                          |
| Class III | D5851    | Tissue conditioning, mandibular                               | \$59.49                | 25.00%                          |
| Class III | D6092    | Recement implant/abutment supported crown                     | \$37.96                | 25.00%                          |
| Class III | D6093    | Recement implant/abutment supported fixed partial denture     | \$54.08                | 25.00%                          |
| Class III | D6210    | Pontic - cast high noble metal                                | \$404.58               | 25.00%                          |
| Class III | D6211    | Pontic - cast predominantly base metal                        | \$385.86               | 25.00%                          |
| Class III | D6212    | Pontic - cast noble metal                                     | \$380.25               | 25.00%                          |
| Class III | D6240    | Pontic - porcelain fused to high noble metal                  | \$404.45               | 25.00%                          |
| Class III | D6241    | Pontic - porcelain fused to predominantly base metal          | \$375.55               | 25.00%                          |
| Class III | D6242    | Pontic - porcelain fused to noble metal                       | \$416.55               | 25.00%                          |
| Class III | D6250    | Pontic - resin with high noble metal                          | \$405.62               | 25.00%                          |
| Class III | D6251    | Pontic - resin with predominantly base metal                  | \$383.87               | 25.00%                          |
| Class III | D6252    | Pontic - resin with noble metal                               | \$367.57               | 25.00%                          |
| Class III | D6600    | Inlay - porcelain/ceramic, two surfaces                       | \$319.97               | 25.00%                          |
| Class III | D6601    | Inlay - porcelain/ceramic, three or more surfaces             | \$339.04               | 25.00%                          |
| Class III | D6602    | Inlay - cast high noble metal, two surfaces                   | \$342.83               | 25.00%                          |
| Class III | D6603    | Inlay - cast high noble metal, three or more surfaces         | \$379.74               | 25.00%                          |
| Class III | D6604    | Inlay - cast predominantly base metal, two surfaces           | \$327.47               | 25.00%                          |
| Class III | D6605    | Inlay - cast predominantly base metal, three or more surfaces | \$353.32               | 25.00%                          |
| Class III | D6606    | Inlay - cast noble metal, two surfaces                        | \$324.42               | 25.00%                          |
| Class III | D6607    | Inlay - cast noble metal, three or more surfaces              | \$353.68               | 25.00%                          |
| Class III | D6608    | Onlay - porcelain/ceramic, two surfaces                       | \$332.50               | 25.00%                          |
| Class III | D6609    | Onlay - porcelain/ceramic, three or more surfaces             | \$344.66               | 25.00%                          |
| Class III | D6610    | Onlay - cast high noble metal, two surfaces                   | \$352.30               | 25.00%                          |
| Class III | D6611    | Onlay - cast high noble metal, three or more surfaces         | \$383.16               | 25.00%                          |
| Class III | D6612    | Onlay - cast predominantly base metal, two surfaces           | \$356.40               | 25.00%                          |
| Class III | D6613    | Onlay - cast predominantly base metal, three or more surfaces | \$364.01               | 25.00%                          |
| Class III | D6614    | Onlay - cast noble metal, two surfaces                        | \$349.04               | 25.00%                          |
| Class III | D6615    | Onlay - cast noble metal, three or more surfaces              | \$354.10               | 25.00%                          |
| Class III | D6720    | Crown - resin with high noble metal                           | \$435.98               | 25.00%                          |
| Class III | D6721    | Crown - resin with predominantly base metal                   | \$395.66               | 25.00%                          |
| Class III | D6722    | Crown - resin with noble metal                                | \$421.91               | 25.00%                          |
| Class III | D6740    | Crown - porcelain/ceramic                                     | \$452.22               | 25.00%                          |



| Class     | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|-----------|----------|---|------------------------|---------------------------------|
| Class III | D6750    | Crown - porcelain fused to high noble metal   | \$440.54               | 25.00%                          |
| Class III | D6751    | Crown - porcelain fused to predominantly base metal   | \$402.92               | 25.00%                          |
| Class III | D6752    | Crown - porcelain fused to noble metal  | \$409.41               | 25.00%                          |
| Class III | D6780    | Crown - ¾ cast high noble metal   | \$443.08               | 25.00%                          |
| Class III | D6790    | Crown - full cast high noble metal  | \$455.93               | 25.00%                          |
| Class III | D6791    | Crown - full cast predominantly base metal  | \$405.05               | 25.00%                          |
| Class III | D6792    | Crown - full cast noble metal   | \$412.07               | 25.00%                          |
| Class III | D6930    | Recement fixed partial denture  | \$54.08                | 25.00%                          |
| Class III | D7210    | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | \$102.23               | 25.00%                          |
| Class III | D7220    | Removal of impacted tooth - soft tissue   | \$130.86               | 25.00%                          |
| Class III | D7230    | Removal of impacted tooth - partially bony  | \$167.12               | 25.00%                          |
| Class III | D7240    | Removal of impacted tooth - completely bony   | \$199.80               | 25.00%                          |
| Class III | D7241    | Removal of impacted tooth - completely bony, with unusual surgical complications  | \$251.26               | 25.00%                          |
| Class III | D7250    | Surgical removal of residual tooth roots (cutting procedure)  | \$108.34               | 25.00%                          |
| Class III | D7310    | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  | \$111.70               | 25.00%                          |
| Class III | D7311    | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  | \$76.00                | 25.00%                          |
| Class III | D7320    | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  | \$157.89               | 25.00%                          |
| Class III | D7321    | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  | \$124.00               | 25.00%                          |
| Class III | D7510    | Incision and drainage of abscess - intraoral soft tissue  | \$104.19               | 25.00%                          |
| Class III | D7520    | Incision and drainage of abscess-extraoral soft tissue  | \$167.00               | 25.00%                          |
| Class III | D7960    | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure                                       | \$117.39               | 25.00%                          |
| Class III | D7970    | Excision hyperplastic tissue - per arch   | \$240.86               | 25.00%                          |
| Class III | D9110    | Palliative (emergency) treatment of dental pain - minor procedure   | \$42.63                | 25.00%                          |
| Class III | D9243    | Intravenous moderate (conscious) sedation/analgesia (each 15 increment).  | \$50.82                | 25.00%                          |
| Class III | D9310    | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician                                       | \$53.00                | 25.00%                          |
| Class III | D9951    | Occlusal adjustment, limited  | \$47.00                | 25.00%                          |
| Class III | D9952    | Occlusal adjustment, complete   | \$274.00               | 25.00%                          |
| Class IV  | D8070    | Comprehensive orthodontic treatment of the transitional dentition   | \$1,850.48             | 25.00%                          |
| Class IV  | D8080    | Comprehensive orthodontic treatment of the adolescent dentition   | \$1,894.03             | 25.00%                          |
| Class IV  | D8090    | Comprehensive orthodontic treatment of the adult dentition  | \$2,072.45             | 25.00%                          |

| Class    | CDT Code | Description   | PPO Network Copayment* | Non-PPO Network Coinsurance +** |
|----------|----------|---|------------------------|---------------------------------|
| Class IV | D8660    | Pre-orthodontic treatment visit   | \$27.55                | 25.00%                          |
| Class IV | D8680    | Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers) | \$382.65               | 25.00%                          |
| Class IV | D8999    | Unspecified orthodontic procedure, by report  | \$250.00               | 25.00%                          |

+ Non-PPO network dentists are paid on the PPO fee schedule.

\* In-Network: Member pays Copayment.

\*\* Out-of-Network: Member pays balance of PPO fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PPO fee.

- a) Procedure codes and descriptions (Current Dental Terminology – CDT) are copyrighted by the American Dental Association. Text that appears in italics was added to clarify the services listed and is not part of CDT procedure code descriptions.
- b) This benefit information is only a brief summary of plan coverage. Please see the Evidence of Coverage for a complete description of plan benefits, limitations and exclusions.
- c) Covered procedures are listed above. Any procedure not listed in the plan is not covered.

LEGAL NOTICES: Access federal and state legal notices related to your plan at [deltadentalins.com/about/legal/index-enrollee.html](http://deltadentalins.com/about/legal/index-enrollee.html)



# Keep Smiling

## Delta Dental PPO™

### Stay in network to save

Visit a dentist in the PPO<sup>1</sup> network to maximize your savings.<sup>2</sup> These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.<sup>3</sup> Find a PPO dentist at [deltadentalins.com](https://deltadentalins.com).

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

### Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at [deltadentalins.com](https://deltadentalins.com).

### Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your

plan, they'll need to provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

### Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

### Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.<sup>4</sup> Log in to your online account to find this date.

### Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care<sup>5</sup>, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

## Save with a PPO dentist



PPO



PREMIER



NON-DELTA DENTAL

<sup>1</sup> In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

<sup>2</sup> You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

<sup>3</sup> You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

<sup>4</sup> Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

<sup>5</sup> Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

**Plan Benefit Highlights for:** City of Tallahassee  
**Group No:** 17452 - PPO Premier

Effective: 01/01/2021

DELTA DENTAL PPO<sup>SM</sup>

BENEFIT HIGHLIGHTS

|  |   |                        |                        |                      |
|--|---|------------------------|------------------------|----------------------|
| <b>Eligibility</b>   | Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the year dependent turns age 26  |                        |                        |                      |
| <b>Deductibles</b>   | <b>Delta Dental PPO dentists:</b> \$25 per person / \$75 per family each calendar year<br><b>Delta Dental Premier dentists:</b> \$25 per person / \$75 per family each calendar year<br><b>Non-Delta Dental dentists:</b> \$50 per person / \$150 per family each calendar year |                        |                        |                      |
| Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics? | Yes   |                        |                        |                      |
| <b>Maximums</b>  | \$1,500 per person each calendar year   |                        |                        |                      |
| D & P counts toward maximum?   | No  |                        |                        |                      |
| <b>Waiting Period(s)</b>   | Basic Services<br>None  | Major Services<br>None | Prosthodontics<br>None | Orthodontics<br>None |

| <b>Benefits and Covered Services*</b>  | <b>Delta Dental PPO dentists*</b> | <b>Delta Dental Premier dentists**</b> | <b>Non-Delta Dental dentists**</b> |
|--|-----------------------------------|--|------------------------------------|
| <b>Diagnostic &amp; Preventive Services (D &amp; P)</b><br>Exams, cleanings, x-rays and sealants | 100%                              | 100%                                   | 100%                               |
| <b>Basic Services</b><br>Fillings and simple extractions   | 80%                               | 80%                                    | 80%                                |
| <b>Endodontics (root canals)</b><br>Covered Under Major Services                                 | 60%                               | 60%                                    | 50%                                |
| <b>Periodontics (gum treatment)</b><br>Covered Under Major Services                              | 60%                               | 60%                                    | 50%                                |
| <b>Oral Surgery</b><br>Covered Under Major Services  | 60%                               | 60%                                    | 50%                                |
| <b>Major Services</b><br>Crowns, inlays, onlays and cast restorations                            | 60%                               | 60%                                    | 50%                                |
| <b>Prosthodontics</b><br>Bridges and dentures  | 60%                               | 60%                                    | 50%                                |
| <b>Orthodontic Benefits</b><br>Dependent children up to age 25                                   | 50%                               | 50%                                    | 50%                                |
| <b>Orthodontic Maximums</b>  | \$1,500 Lifetime                  | \$1,500 Lifetime                       | \$1,500 Lifetime                   |

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

|  |   |   |
|--|---|---|
| <b>Delta Dental Insurance Company</b><br>1130 Sanctuary Parkway, Suite 600<br>Alpharetta, GA 30009 | <b>Customer Service</b><br>800-521-2651 | <b>Claims Address</b><br>P.O. Box 1809<br>Alpharetta, GA 30023-1809 |
|--|---|---|

[deltadentalins.com](http://deltadentalins.com)

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

# Keep Smiling

## Delta Dental PPO™



### Save with PPO

Visit a dentist in the PPO<sup>1</sup> network to maximize your savings.<sup>2</sup> These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.<sup>3</sup> Find a PPO dentist at [deltadentalins.com](https://deltadentalins.com).

### Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at [deltadentalins.com](https://deltadentalins.com).

### Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

### Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

### Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.<sup>4</sup> Log in to your online account to find this date.

### Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care<sup>5</sup>, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

## Save with a PPO dentist



<sup>1</sup> In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

<sup>2</sup> You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

<sup>3</sup> You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

<sup>4</sup> Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

<sup>5</sup> Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

**Plan Benefit Highlights for:** City of Tallahassee

**Group No:** 17452

PPO/Plus Plan

**Effective Date:** 01/01/2021

DELTA DENTAL PPO<sup>SM</sup>

BENEFIT HIGHLIGHTS

|  |   |                        |                        |                      |
|--|---|------------------------|------------------------|----------------------|
| <b>Eligibility</b>   | Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the year dependent turns age 26  |                        |                        |                      |
| <b>Deductibles</b>   | <b>Delta Dental PPO dentists:</b><br>\$25 per person / \$75 per family each calendar year<br><b>Non-Delta Dental PPO dentists:</b><br>\$50 per person / \$150 per family each calendar year |                        |                        |                      |
| Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics? | Yes   |                        |                        |                      |
| <b>Maximums</b>  | \$1,500 per person each calendar year   |                        |                        |                      |
| D & P counts toward maximum?   | No  |                        |                        |                      |
| <b>Waiting Period(s)</b>   | Basic Services<br>None  | Major Services<br>None | Prosthodontics<br>None | Orthodontics<br>None |

| <b>Benefits and Covered Services*</b>  | <b>Delta Dental PPO dentists**</b> | <b>Non-Delta Dental PPO dentists**</b> |
|--|------------------------------------|--|
| <b>Diagnostic &amp; Preventive Services (D &amp; P)</b><br>Exams, cleanings, x-rays and sealants | 100%                               | 80%                                    |
| <b>Basic Services</b><br>Fillings and simple extractions   | 80%                                | 60%                                    |
| <b>Endodontics (root canals)</b><br>Covered Under Major Services                                 | 60%                                | 50%                                    |
| <b>Periodontics (gum treatment)</b><br>Covered Under Major Services                              | 60%                                | 50%                                    |
| <b>Oral Surgery</b><br>Covered Under Major Services  | 60%                                | 50%                                    |
| <b>Major Services</b><br>Crowns, inlays, onlays and cast restorations                            | 60%                                | 50%                                    |
| <b>Prosthodontics</b><br>Bridges, dentures and implants  | 60%                                | 50%                                    |
| <b>Orthodontic Benefits</b><br>Dependent children to age 25                                      | 50%                                | 50%                                    |
| <b>Orthodontic Maximums</b>  | \$1,800 Lifetime                   | \$1,500 Lifetime                       |

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

|  |   |   |
|--|---|---|
| <b>Delta Dental Insurance Company</b><br>1130 Sanctuary Parkway, Suite 600<br>Alpharetta, GA 30009 | <b>Customer Service</b><br>800-521-2651 | <b>Claims Address</b><br>P.O. Box 1809<br>Alpharetta, GA 30023-1809 |
|--|---|---|

**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.



Delta Dental Insurance Company

**CITY OF TALLAHASSEE**

*Copayments and Coinsurance Plans*

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*Primary Enrollee's Name*



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deltadentalins.com

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**Group No: 17452-00003**

**Effective Date: January 1, 2017**

**This Certificate Contains a Deductible**

**Table of Contents**

INTRODUCTION ..... 1

DEFINITIONS ..... 2

PREMIUMS ..... 4

ELIGIBILITY AND ENROLLMENT ..... 4

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED ..... 6

SELECTING YOUR PROVIDER ..... 9

CLAIMS APPEAL ..... 10

GENERAL PROVISIONS..... 11

**Attachments**

- ATTACHMENT A: OFFICE VISITS COPAYS, DEDUCTIBLES, MAXIMUMS AND CONTRACT BENEFIT LEVELS
- ATTACHMENT A-1: TABLE OF ENROLLEE COPAYMENTS
- ATTACHMENT B: SERVICES, LIMITATIONS AND EXCLUSIONS
- NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION



## INTRODUCTION

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

### Using This Evidence of Coverage

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

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

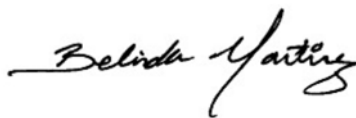
**Notice:** *This booklet is a summary of your group dental plan and must be in effect at the time covered dental services are provided. This information is not a guarantee of covered benefits, services or payments.*

### Contact Us

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

You can access our automated information line at 800-521-2651 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance, including the resolution of complaints. If you prefer to write us with your question(s), please mail your inquiry to the following address:

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



Belinda Martinez, President

## DEFINITIONS

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

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

**Benefits:** covered dental services provided under the terms of the Contract.

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

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

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

**Contract Benefit Level:** the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied as shown in Attachment A.

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

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

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

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

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

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

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

**Dependent Enrollee:** an Eligible Dependent enrolled to receive Benefits.

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

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

**Eligible Employee:** any employee as eligible for Benefits.

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

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

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

**Maximum:** is the maximum dollar amount (“Maximum Amount” or “Maximum”) Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under the Contract.

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

- by a PPO Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider’s Submitted Fee or the Program Allowance.

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

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

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

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

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

**Program Allowance:** the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental sets the Program Allowance for each procedure through a review of proprietary data by geographic area. The Program Allowance may vary by the contracting status of the Provider and/or the Program Allowance selected by the Contractholder.

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

**Qualifying Status Change:** a change in:

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

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

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

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

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

**Table of Copayments:** the list of covered dental services showing the Procedure Code and the amount the Enrollee would pay for each covered Single Procedure as shown in Attachment A-1.

## PREMIUMS

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

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

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

## ELIGIBILITY AND ENROLLMENT

### Eligibility Requirements

You will become eligible to receive Benefits on the date stated in the Contract after completing any eligibility periods required by the Contractholder as stated in the Contract.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

- Dependents are the Primary Enrollee's Spouse and dependent children from birth to the end of the Calendar Year of their 26<sup>th</sup> birthday.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption, custodial children, children for which the employee has been appointed legal guardian and newborn children, including a newborn child of a covered dependent child and children of a partner as recognized by the Contractholder. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a Dependent, becomes a Primary Enrollee.
- Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children, foster children and custodial children are eligible from the moment of placement in the Enrollee's residence. Notice of birth, adoption placement, foster home placement or other custodial placement of a child with Enrollee must be received no later than 31 days after the birth or placement. If notice of birth or adoption is received no later than 31 days after birth or placement, no additional premiums are due during the notice period. If notice is received no later than 60 days after the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.
- Children who reach the limiting age are eligible if:
  - (1) he or she is incapable of self-sustaining employment because of an intellectual or physical disability;
  - (2) he or she is chiefly dependent on the eligible employee for support; and
  - (3) proof of dependent child's disability is provided. Eligibility will continue as long as the dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

### Enrollment Requirements

If the Contractholder is paying all premiums for you and your dependents, everyone is automatically enrolled.

If you are paying all or a portion of premiums for yourself or your dependents then:

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.

- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay Premiums in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay Premiums for your Dependent Enrollees, you must pay the Premiums in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. If notice of a birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of a birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

### Loss of Eligibility

Your coverage ends on the earlier of the last day of the month you stop working for the Contractholder, are no longer an Eligible Employee of the Contractholder or immediately when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or the end of the Calendar Year when dependent status is lost.

### Continuation of Benefits

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

A dental service is incurred:

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

### Strike, Lay-off and Leave of Absence

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

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

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

Coverage will resume provided the Contractholder submits a request to Delta Dental that coverage be reactivated.

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

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

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

## Extension of Benefits

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

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

The extension of Benefits terminates upon the earlier of:

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

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

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

## Continued Coverage under USERRA

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

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

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

## Continuation of Coverage Under COBRA

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

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

## CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. Delta Dental will provide advance notice of such changes to the Contractholder who will then distribute to Primary Enrollees.

We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A. If you receive dental services from a Provider outside the state of Florida, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

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

### **Enrollee Coinsurance**

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

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

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

### **Deductible**

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

### **Maximum Amount**

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

### **Pre-Treatment Estimate**

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

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

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

### Coordination of Benefits

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

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



- (6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
  - a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
  - b) Second, the Benefits under the continuation coverage.If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.
- (9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

## SELECTING YOUR PROVIDER

### Free Choice of Provider

You may see any Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. **This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider.** To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment. Review this section for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

### Locating a PPO Provider

You may access information through our website at [deltadentalins.com](http://deltadentalins.com). You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network participation, specialty and office location.

### Choosing a PPO Provider

A PPO Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

### Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but no more than the Delta Dental Premier Contracted Fee.

### Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

### **Additional Obligations of PPO and Premier Providers**

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- PPO and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

### **How to Submit a Claim**

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

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

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

### **Payment Guidelines**

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO Provider that you were covered under a Delta Dental Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

### **Provider Relationships**

Enrollees and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

### **CLAIMS APPEAL**

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

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

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

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

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

## **GENERAL PROVISIONS**

### **Non-Discrimination**

Delta Dental is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

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

### **Clinical Examination**

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

### **Notice of Claim Form**

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

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

**Written Notice of Claim/Proof of Loss**

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

**Time of Payment**

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

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

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

**To Whom Benefits Are Paid**

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

**Misstatements on Application: Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at enrollment.

**Legal Actions**

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

**Automated Information Line**

You may access Delta Dental's automated information line at 800-521-2651 on a regular business day to obtain your eligibility and Benefits, group benefit or claim status information or to speak to a Customer Service Representative for assistance, including the resolution of complaints.

**Conformity With Prevailing Laws**

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

**Attachment A**  
**Office Visit Copays, Deductibles, Maximums and Contract Benefit Levels**

**NOTICE** – this plan contains an Office Visit Copay for PPO Providers and a Deductible for Premier and Non-Delta Dental Providers.

**Contractholder:** City of Tallahassee

**Group Number:** 17452-00003      **Effective Date:** January 1, 2017

| <b>Deductibles &amp; Maximums</b>   |  |  |
|-------------------------------------|--|--|
|                                     | <b>Delta Dental PPO<sup>SM</sup> Providers<sup>†</sup></b>   | <b>Delta Dental Premier<sup>®</sup> and Non-Delta Dental Providers<sup>†</sup></b> |
| <b>Office Visit Copay</b>           | \$0 per Enrollee per visit to Dental Provider  | \$0 per Enrollee   |
| <b>Annual Deductible</b>            | \$0 per Enrollee each Calendar Year  | \$50 per Enrollee each Calendar Year<br>\$150 per family each Calendar Year        |
| Deductibles waived for              | N/A  | Diagnostic & Preventive and Orthodontic Services                                   |
| <b>Annual Maximum</b>               | Unlimited per Enrollee per Calendar Year   | \$500 per Enrollee per Calendar Year   |
| <b>Lifetime Orthodontic Maximum</b> | N/A  | \$500 per Primary Enrollee, Spouse and dependent child Enrollee to age 25          |
| Maximum Takeover Credit             | Delta Dental will receive credit for any amount paid under the Contractholder's previous dental care plan, if applicable, for Orthodontic Services. These amounts will be credited towards the maximum amounts payable for Orthodontic Services. |  |

| <b>Contract Benefit Levels</b>            |   |  |
|---|---|--|
| <b>Dental Service Category</b>            | <b>Delta Dental PPO<sup>SM</sup> Providers<sup>†</sup></b>  | <b>Delta Dental Premier<sup>®</sup> and Non-Delta Dental Providers<sup>†</sup></b> |
| <b>Diagnostic and Preventive Services</b> | Delta Dental will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment as shown on Attachment A-1. | 50%  |
| <b>Basic Services</b>                     | Delta Dental will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment as shown on Attachment A-1. | 40%  |
| <b>Major Services</b>                     | Delta Dental will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment as shown on Attachment A-1. | 25%  |
| <b>Orthodontic Services</b>               | Delta Dental will pay an amount equal to the Maximum Contract Allowance less the Enrollee Copayment as shown on Attachment A-1. | 25%  |

<sup>†</sup> Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

## Attachment A-1 Table of Enrollee Copayments

### Table of Enrollee Copayments – Delta Dental PPO Providers<sup>SM</sup>

**Please note the following:**

- When covered services are provided by a PPO Provider, the Enrollee will pay the amounts listed in the Enrollee Copayments column and Delta Dental will pay the Maximum Contract Allowance less the Enrollee Copayment listed in the Enrollee Copayments column. Orthodontic Services will be covered at the Contract Benefit Levels shown on Attachment A (Office Visit Copays, Deductibles, Maximums and Contract Benefit Levels).
- All covered services are subject to the limitations and exclusions listed in this Certificate.
- The below codes and nomenclature are copyright of the American Dental Association and represent the codes and nomenclature excerpted from the version of Current Dental Terminology (CDT) in effect at the date of this document's release. Delta Dental's administration of benefits, limitations and exclusions under this plan at all times will be based on the then current version of CDT whether or not a revised table is provided.

**Notice:** An Office Visit Copay must be paid each visit in addition to Enrollee Copayments when covered services are provided by a PPO Provider.

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

| PROCEDURE NUMBER | PROCEDURE DESCRIPTION  | ENROLLEE COPAYMENTS |
|------------------|--|---------------------|
| D0120            | Periodic oral evaluation - established patient   | \$0.00              |
| D0140            | Limited oral evaluation - problem focused  | \$0.00              |
| D0145            | Oral evaluation for a patient under three years of age and counseling with primary caregiver | \$0.00              |
| D0150            | Comprehensive oral evaluation - new or established patient                                   | \$0.00              |
| D0160            | Detailed and extensive oral evaluation - problem focused, by report                          | \$0.00              |
| D0170            | Re-evaluation - limited, problem focused (established patient; not post-operative visit)     | \$0.00              |
| D0180            | Comprehensive periodontal evaluation - new or established patient                            | \$0.00              |
| D0210            | Intraoral - complete series of radiographic images   | \$0.00              |
| D0220            | Intraoral - periapical - first radiographic image  | \$0.00              |
| D0230            | Intraoral - periapical - each additional radiographic image                                  | \$0.00              |
| D0240            | Intraoral - occlusal radiographic image  | \$0.00              |
| D0270            | Bitewing - single radiographic image   | \$0.00              |
| D0272            | Bitewings - two radiographic images  | \$0.00              |
| D0273            | Bitewings - three radiographic images  | \$0.00              |
| D0274            | Bitewings - four radiographic images   | \$0.00              |
| D0277            | Vertical bitewings - seven to eight radiographic images                                      | \$0.00              |
| D0330            | Panoramic radiographic image   | \$0.00              |
| D0340            | Cephalometric radiographic image   | \$0.00              |
| D0350            | 2D oral/facial photographic image obtained intra-orally or extra-orally                      | \$0.00              |
| D0460            | Pulp vitality tests  | \$0.00              |
| D0470            | Diagnostic casts   | \$0.00              |
| D1110            | Prophylaxis - adult  | \$0.00              |
| D1120            | Prophylaxis - child  | \$0.00              |
| D1206            | Topical application of fluoride varnish  | \$0.00              |
| D1208            | Topical application of fluoride - excluding varnish  | \$0.00              |
| D1351            | Sealant - per tooth  | \$0.00              |
| D1510            | Space maintainer - fixed, unilateral   | \$48.80             |
| D1515            | Space maintainer - fixed, bilateral  | \$64.89             |
| D1520            | Space maintainer - removable, unilateral   | \$62.68             |

| <b>PROCEDURE NUMBER</b> | <b>PROCEDURE DESCRIPTION</b>   | <b>ENROLLEE COPAYMENTS</b> |
|-------------------------|--|----------------------------|
| D1525                   | Space maintainer - removable, bilateral  | \$87.01                    |
| D1550                   | Re-cement or re-bond space maintainer  | \$10.88                    |
| D2140                   | Amalgam - one surface, primary or permanent  | \$21.49                    |
| D2150                   | Amalgam - two surfaces, primary or permanent   | \$27.03                    |
| D2160                   | Amalgam - three surfaces, primary or permanent                                       | \$31.97                    |
| D2161                   | Amalgam - four or more surfaces, primary or permanent                                | \$39.89                    |
| D2330                   | Resin-based composite - one surface, anterior  | \$20.92                    |
| D2331                   | Resin-based composite - two surface, anterior  | \$27.84                    |
| D2332                   | Resin-based composite - three surfaces, anterior                                     | \$34.55                    |
| D2335                   | Resin-based composite - four or more surfaces or involving incisal angle (anterior). | \$40.59                    |
| D2390                   | Resin-based composite crown, anterior  | \$45.46                    |
| D2391                   | Resin-based composite - one surface, posterior                                       | \$23.64                    |
| D2392                   | Resin-based composite - two surfaces, posterior                                      | \$33.21                    |
| D2393                   | Resin-based composite - three surfaces, posterior                                    | \$40.79                    |
| D2394                   | Resin-based composite - four or more surfaces, posterior                             | \$46.30                    |
| D2510                   | Inlay - metallic - one surface   | \$273.03                   |
| D2520                   | Inlay - metallic - two surfaces  | \$343.77                   |
| D2530                   | Inlay - metallic - three or more surfaces  | \$377.55                   |
| D2542                   | Onlay - metallic - two surfaces  | \$386.01                   |
| D2543                   | Onlay - metallic - three surfaces  | \$379.24                   |
| D2544                   | Onlay - metallic - four or more surfaces   | \$391.33                   |
| D2610                   | Inlay - porcelain/ceramic - one surface  | \$321.30                   |
| D2620                   | Inlay - porcelain/ceramic - two surfaces   | \$376.33                   |
| D2630                   | Inlay - porcelain/ceramic - three or more surfaces                                   | \$381.32                   |
| D2642                   | Onlay - porcelain/ceramic - two surfaces   | \$387.05                   |
| D2643                   | Onlay - porcelain/ceramic - three surfaces   | \$391.83                   |
| D2644                   | Onlay - porcelain/ceramic - four or more surfaces                                    | \$412.54                   |
| D2650                   | Inlay - resin-based composite - one surface  | \$214.90                   |
| D2651                   | Inlay - resin-based composite - two surfaces   | \$272.63                   |
| D2652                   | Inlay - resin-based composite - three or more surfaces                               | \$255.28                   |
| D2662                   | Onlay - resin-based composite - two surfaces   | \$248.04                   |
| D2663                   | Onlay - resin-based composite - three surfaces                                       | \$291.80                   |
| D2664                   | Onlay - resin-based composite - four or more surfaces                                | \$286.48                   |
| D2710                   | Crown - resin-based composite (indirect)   | \$163.91                   |
| D2720                   | Crown - resin with high noble metal  | \$424.03                   |
| D2721                   | Crown - resin with predominantly base metal  | \$379.83                   |
| D2722                   | Crown - resin with noble metal   | \$406.25                   |
| D2740                   | Crown - porcelain/ceramic substrate  | \$430.58                   |
| D2750                   | Crown - porcelain fused to high noble metal  | \$422.41                   |
| D2751                   | Crown - porcelain fused to predominantly base metal                                  | \$386.02                   |
| D2752                   | Crown - porcelain fused to noble metal   | \$392.65                   |
| D2790                   | Crown - full cast high noble metal   | \$437.46                   |
| D2791                   | Crown - full cast predominantly base metal   | \$387.76                   |
| D2792                   | Crown - full cast noble metal  | \$387.94                   |
| D2910                   | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration            | \$38.63                    |
| D2920                   | Re-cement or re-bond crown   | \$37.96                    |

| <b>PROCEDURE NUMBER</b> | <b>PROCEDURE DESCRIPTION</b>  | <b>ENROLLEE COPAYMENTS</b> |
|-------------------------|---|----------------------------|
| D2930                   | Prefabricated stainless steel crown - primary tooth   | \$109.21                   |
| D2931                   | Prefabricated stainless steel crown - permanent tooth   | \$125.20                   |
| D2932                   | Prefabricated resin crown   | \$125.58                   |
| D2940                   | Protective restoration  | \$42.37                    |
| D2950                   | Core build-up, including any pins   | \$103.18                   |
| D2951                   | Pin retention - per tooth, in addition to restoration   | \$21.52                    |
| D2952                   | Post and core in addition to crown, indirectly fabricated   | \$160.21                   |
| D2954                   | Prefabricated post and core in addition to crown  | \$129.56                   |
| D3220                   | Therapeutic pulpotomy (excluding final restoration)   | \$61.56                    |
| D3310                   | Endodontic therapy, anterior tooth (excluding final restoration)  | \$303.70                   |
| D3320                   | Endodontic therapy, bicuspid tooth (excluding final restoration)  | \$341.88                   |
| D3330                   | Endodontic therapy, molar (excluding final restoration)   | \$464.62                   |
| D3346                   | Retreatment of previous root canal therapy - anterior   | \$357.52                   |
| D3347                   | Retreatment of previous root canal therapy - bicuspid   | \$432.53                   |
| D3348                   | Retreatment of previous root canal therapy - molar  | \$544.29                   |
| D3410                   | Apicoectomy - anterior  | \$293.42                   |
| D3421                   | Apicoectomy - bicuspid (first root)   | \$335.37                   |
| D3425                   | Apicoectomy - molar (first root)  | \$349.93                   |
| D3426                   | Apicoectomy (each additional root)  | \$126.75                   |
| D3430                   | Retrograde filling - per root   | \$94.64                    |
| D4210                   | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant  | \$301.00                   |
| D4211                   | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant  | \$131.97                   |
| D4240                   | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant                            | \$359.17                   |
| D4241                   | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant                            | \$186.74                   |
| D4249                   | Clinical crown lengthening - hard tissue  | \$361.00                   |
| D4260                   | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | \$553.00                   |
| D4261                   | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | \$292.43                   |
| D4341                   | Periodontal scaling and root planing - four or more teeth per quadrant  | \$35.70                    |
| D4342                   | Periodontal scaling and root planing - one to three teeth, per quadrant   | \$18.74                    |
| D4355                   | Full mouth debridement to enable comprehensive evaluation and diagnosis   | \$24.07                    |
| D4910                   | Periodontal maintenance procedure   | \$21.03                    |
| D5110                   | Complete denture - maxillary  | \$592.10                   |
| D5120                   | Complete denture - mandibular   | \$592.10                   |
| D5130                   | Immediate denture - maxillary   | \$645.42                   |
| D5140                   | Immediate denture - mandibular  | \$645.42                   |
| D5211                   | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)   | \$536.87                   |
| D5212                   | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)  | \$623.05                   |
| D5213                   | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)                  | \$657.40                   |
| D5214                   | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)                 | \$657.40                   |
| D5410                   | Adjust complete denture - maxillary   | \$33.37                    |
| D5411                   | Adjust complete denture - mandibular  | \$33.37                    |



| <b>PROCEDURE NUMBER</b> | <b>PROCEDURE DESCRIPTION</b>  | <b>ENROLLEE COPAYMENTS</b> |
|-------------------------|---|----------------------------|
| D5421                   | Adjust partial denture - maxillary                                    | \$33.37                    |
| D5422                   | Adjust partial denture - mandibular                                   | \$33.37                    |
| D5510                   | Repair broken complete denture base                                   | \$66.67                    |
| D5520                   | Replace missing broken tooth - complete denture (each tooth)          | \$56.22                    |
| D5610                   | Repair resin denture base   | \$71.63                    |
| D5620                   | Repair cast framework   | \$77.65                    |
| D5630                   | Repair or replace broken clasp  | \$93.70                    |
| D5640                   | Replace broken teeth - per tooth                                      | \$60.99                    |
| D5650                   | Add tooth to existing partial denture                                 | \$82.61                    |
| D5660                   | Add clasp to existing partial denture                                 | \$98.39                    |
| D5710                   | Rebase complete maxillary denture                                     | \$250.08                   |
| D5711                   | Rebase complete mandibular denture                                    | \$238.59                   |
| D5720                   | Rebase maxillary partial denture                                      | \$239.22                   |
| D5721                   | Rebase mandibular partial denture                                     | \$239.22                   |
| D5730                   | Reline complete maxillary denture (chairside)                         | \$139.96                   |
| D5731                   | Reline complete mandibular denture (chairside)                        | \$139.96                   |
| D5740                   | Reline maxillary partial denture (chairside)                          | \$126.40                   |
| D5741                   | Reline mandibular partial denture (chairside)                         | \$126.40                   |
| D5750                   | Reline complete maxillary denture (laboratory)                        | \$182.45                   |
| D5751                   | Reline complete mandibular denture (laboratory)                       | \$182.45                   |
| D5760                   | Reline maxillary partial denture (laboratory)                         | \$185.58                   |
| D5761                   | Reline mandibular partial denture (laboratory)                        | \$185.58                   |
| D5850                   | Tissue conditioning - maxillary                                       | \$59.49                    |
| D5851                   | Tissue conditioning - mandibular                                      | \$59.49                    |
| D6092                   | Re-cement or re-bond implant/abutment supported crown                 | \$37.96                    |
| D6093                   | Re-cement or re-bond implant/abutment supported fixed partial denture | \$54.08                    |
| D6210                   | Pontic - cast high noble metal  | \$404.58                   |
| D6211                   | Pontic - cast predominantly base metal                                | \$385.86                   |
| D6212                   | Pontic - cast noble metal   | \$380.25                   |
| D6240                   | Pontic - porcelain fused to high noble metal                          | \$404.45                   |
| D6241                   | Pontic - porcelain fused to predominantly base metal                  | \$375.55                   |
| D6242                   | Pontic - porcelain fused to noble metal                               | \$416.55                   |
| D6250                   | Pontic - resin with high noble metal                                  | \$405.62                   |
| D6251                   | Pontic - resin with predominantly base metal                          | \$383.87                   |
| D6252                   | Pontic - resin with noble metal                                       | \$367.57                   |
| D6600                   | Inlay - porcelain/ceramic, two surfaces                               | \$319.97                   |
| D6601                   | Inlay - porcelain/ceramic, three or more surfaces                     | \$339.04                   |
| D6602                   | Inlay - cast high noble metal, two surfaces                           | \$342.83                   |
| D6603                   | Inlay - cast high noble metal, three or more surfaces                 | \$379.74                   |
| D6604                   | Inlay - cast predominately base metal, two surfaces                   | \$327.47                   |
| D6605                   | Inlay - cast predominately base metal, three or more surfaces         | \$353.32                   |
| D6606                   | Inlay - cast noble metal, two surfaces                                | \$324.42                   |
| D6607                   | Inlay - cast noble metal, three or more surfaces                      | \$353.68                   |
| D6608                   | Onlay - porcelain/ceramic, two surfaces                               | \$332.50                   |
| D6609                   | Onlay - porcelain/ceramic, three or more surfaces                     | \$344.66                   |
| D6610                   | Onlay - cast high noble metal, two surfaces                           | \$352.30                   |
| D6611                   | Onlay - cast high noble metal, three or more surfaces                 | \$383.16                   |

| <b>PROCEDURE NUMBER</b> | <b>PROCEDURE DESCRIPTION</b>  | <b>ENROLLEE COPAYMENTS</b> |
|-------------------------|---|----------------------------|
| D6612                   | Onlay - cast predominately base metal, two surfaces   | \$356.40                   |
| D6613                   | Onlay - cast predominately base metal, three or more surfaces   | \$364.01                   |
| D6614                   | Onlay - cast noble metal, two surfaces  | \$349.04                   |
| D6615                   | Onlay - cast noble metal, three or more surfaces  | \$354.10                   |
| D6720                   | Crown - resin with high noble metal   | \$435.98                   |
| D6721                   | Crown - resin with predominantly base metal   | \$395.66                   |
| D6722                   | Crown - resin with noble metal  | \$421.91                   |
| D6740                   | Crown - porcelain/ceramic   | \$452.22                   |
| D6750                   | Crown - porcelain fused to high noble metal   | \$440.54                   |
| D6751                   | Crown - porcelain fused to predominantly base metal   | \$402.92                   |
| D6752                   | Crown - porcelain fused to noble metal  | \$409.41                   |
| D6780                   | Crown - 3/4 cast high noble metal   | \$443.08                   |
| D6790                   | Crown - full cast high noble metal  | \$455.93                   |
| D6791                   | Crown - full cast predominantly base metal  | \$405.05                   |
| D6792                   | Crown - full cast noble metal   | \$412.07                   |
| D6930                   | Re-cement or re-bond fixed partial denture  | \$54.08                    |
| D7111                   | Extraction, coronal remnants - deciduous tooth  | \$19.31                    |
| D7140                   | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)  | \$24.31                    |
| D7210                   | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | \$102.23                   |
| D7220                   | Removal of impacted tooth - soft tissue   | \$130.86                   |
| D7230                   | Removal of impacted tooth - partially bony  | \$167.12                   |
| D7240                   | Removal of impacted tooth - completely bony   | \$199.80                   |
| D7241                   | Removal of impacted tooth - completely bony, with unusual surgical complications  | \$251.26                   |
| D7250                   | Surgical removal of residual tooth roots (cutting procedure)  | \$108.34                   |
| D7310                   | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  | \$111.70                   |
| D7311                   | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  | \$76.00                    |
| D7320                   | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant  | \$157.89                   |
| D7321                   | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant  | \$124.00                   |
| D7510                   | Incision and drainage of abscess - intraoral soft tissue  | \$104.19                   |
| D7520                   | Incision and drainage of abscess - extraoral soft tissue  | \$167.00                   |
| D7960                   | Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure                                       | \$117.39                   |
| D7970                   | Excision of hyperplastic tissue - per arch  | \$240.86                   |
| D9110                   | Palliative (emergency) treatment of dental pain - minor procedures  | \$42.63                    |
| D9223                   | Deep sedation/general anesthesia - each 15 minute increment   | \$50.82                    |
| D9243                   | Intravenous moderate (conscious) sedation/analgesia - each 15 minutes   | \$50.82                    |
| D9310                   | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician                                       | \$53.00                    |
| D9951                   | Occlusal adjustment, limited  | \$47.00                    |
| D9952                   | Occlusal adjustment, complete   | \$274.00                   |
| D8070                   | Comprehensive orthodontic treatment of the transitional dentition   | \$1,850.48                 |
| D8080                   | Comprehensive orthodontic treatment of the adolescent dentition   | \$1,894.03                 |
| D8090                   | Comprehensive orthodontic treatment of the adult dentition  | \$2,072.45                 |
| D8660                   | Pre-orthodontic treatment visit   | \$27.55                    |

| <b>PROCEDURE NUMBER</b> | <b>PROCEDURE DESCRIPTION</b>   | <b>ENROLLEE COPAYMENTS</b> |
|-------------------------|--|----------------------------|
| D8680                   | Orthodontic retention (removal of appliances, construction and placement of removable retainers) | \$382.65                   |
| D8999                   | Unspecified orthodontic procedure, by report   | \$250.00                   |

## Attachment B Services, Limitations and Exclusions

**Contractholder:** City of Tallahassee

**Group Number:** 17452-00003

**Effective Date:** January 1, 2017

### ***Description of Dental Services***

Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (periodontal maintenance, which is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

- (1) Simple Extractions: extractions of erupted tooth or exposed root.
- (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- (3) Non-Surgical Periodontics: non-surgical periodontal treatment of gums and bones supporting teeth.
- (4) Basic Restorative: amalgam and resin-based composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (5) Space Maintainers: passive appliances designed to keep the space open to allow the permanent tooth to erupt and come into place.

- **Major Services**

- (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges.
- (3) Oral Surgery: surgical extractions and certain other surgical procedures (including pre-and post-operative care).
- (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (5) Surgical Periodontal services: surgical periodontal treatment of gums and bones supporting teeth.
- (6) Palliative: emergency treatment to relieve pain.
- (7) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- (8) Specialist Consultations: opinion or advice requested by a general dentist.
- (9) Major Restorative: prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Orthodontic Services**

Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- **Note on additional Benefits during pregnancy**

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

**Limitations**

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

- a) a composite restoration instead of an amalgam restoration on posterior teeth;
- b) a crown where a filling would restore the tooth;
- c) an inlay/onlay instead of an amalgam restoration; or
- d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Exam and cleaning limitations

- a) Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
- b) Note that periodontal maintenance and Procedure Codes that include periodontal maintenance are covered as a Basic Benefit and that routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- c) Caries risk assessments are allowed once in 36 months.

- (3) X-ray limitations:

- a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

- (4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than once in a Calendar Year.

- (5) Space maintainer limitations:

- a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.
- b) Recementation of space maintainer is limited to once per lifetime.
- c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

- (6) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.
- (8) Sealants are limited as follows:
  - a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
  - b) do not include repair or replacement of a Sealant on any tooth within 24 months of its application.
- (9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.
- (10) Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
- (11) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (12) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- (13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only.
- (14) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (16) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (17) Periodontal limitations:
  - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service.
  - b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.
  - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  - e) Cleanings (regular and periodontal) is subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- (18) Oral Surgery services are covered once in a lifetime except incision and drainage procedures, which are covered once in the same day.
- (19) The following Oral Surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.

- (20) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- (21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (22) Core buildup, including any pins, are covered not more than once in any 60 month period.
- (23) Post and core services are covered not more than once in any 60 month year period.
- (24) Crown repairs are covered not more than twice in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- (25) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
- (26) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.
- (27) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
- (28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the removable partial denture will be a Benefit.
- (29) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- (30) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
  - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
  - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
  - c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
  - d) Recementation of fixed partial dentures is limited to once in a lifetime.
- (31) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown, pontic or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture. The implant appliance is not covered.

- (32) Limitations on Orthodontic Services:
- a) The maximum amount payable for each Enrollee is shown in Attachment A.
  - b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
  - c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
  - d) Benefits are not paid for orthodontic retreatment procedures.
  - e) Benefits for Orthodontic Services are limited to Primary Enrollee, Spouse and dependent child Enrollees to age 25.

**Exclusions**

**Delta Dental does not pay Benefits for:**

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate and cleft lip (unless services for cleft palate and cleft lip are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn or adopted children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) laboratory processed crowns for Enrollees under age 12.
- (12) fixed bridges and removable partials for Enrollees under age 16.
- (13) interim implants and endodontic endosseous implant.
- (14) indirectly fabricated resin-based Inlays/Onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.



- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- (24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) missed and/or cancelled appointments.
- (26) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (27) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (28) dental case management motivational interviewing and patient education to improve oral health literacy.
- (29) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (30) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

## **HIPAA Notice of Privacy Practices**

### **CONFIDENTIALITY OF YOUR HEALTH INFORMATION**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

### **PERMITTED USES AND DISCLOSURES OF YOUR PHI**

#### **Uses and disclosures of your PHI for treatment, payment or health care operations**

Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health

care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

### **Other permitted uses and disclosures without an authorization**

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

### **Disclosures Delta Dental makes with your authorization**

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

## **YOUR RIGHTS REGARDING PHI**

### **You have the right to request an inspection of and obtain a copy of your PHI.**

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

### **You have the right to request a restriction of your PHI.**

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

### **You have the right to correct or update your PHI.**

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

### **You have rights related to the use and disclosure of your PHI for marketing.**

Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt-out of marketing that is permitted by law without an authorization. Delta Dental does not use your PHI for fundraising purposes.

### **You have the right to request or receive confidential communications from us by alternative means or at a different address.**

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger,

as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by email.**

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

**You have the right to be notified following a breach of unsecured protected health information.**

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

**COMPLAINTS**

You may file a complaint with Delta Dental and/or with the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

**CONTACTS**

You may contact Delta Dental at 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental  
P.O. Box 997330  
Sacramento, CA 95899-7330

This notice is effective on and after January 1, 2017.

*Note: Delta Dental's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.*

**Last Significant Changes to this notice:**

- Clarified that Delta Dental does not use your PHI for fundraising purposes. Effective January 1, 2016
- Clarified that Delta Dental's privacy policy reflect federal and state requirements. – effective January 1, 2015
- Updated contact information (mailing address and phone number) – effective July 1, 2013
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
- Clarified that Delta Dental does not and will not sell your information without your express written authorization – effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013

**DELTA DENTAL AND ITS AFFILIATES**

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia.

Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Dentegra Insurance Company.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-521-2651 (TTY: 711).

¿Puede leer este documento? Si no, podemos hacer que alguien lo lea por usted. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-521-2651 (TTY: 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-521-2651 (TTY: 711)。 (Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-521-2651 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 그렇지 않다면, 다른 사람이 대신 읽어드리도록 도와드릴 수 있습니다. 또한 이 문서를 귀하의 모국어로 번역해드릴 수 있습니다. 무료 지원을 요청하시려면, 1-800-521-2651 (TTY: 711)번으로 연락하십시오. (Korean)

Mababasa mo ba ang dokumentong ito? Kung hindi, mayroong makatutulong sa iyo na basahin ito. Maaring makuha mo rin ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-521-2651 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, то вы можете попросить кого-нибудь в нашей компании помочь вам прочитать этот документ. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-521-2651 (TTY: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نُوفّر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك. للمساعدة المجانية اتصل بـ 1-800-521-2651 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-521-2651 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-521-2651 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-521-2651 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-521-2651 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche essere in grado di ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-521-2651 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には、読むためのお手伝いをさせていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-521-2651 (TTY: 711) までご連絡ください。 (Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-521-2651 (TTY: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخوایا تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-521-2651 (TTY: 711). (Persian Farsi)

קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט, עמעצער דו קען אייך העלפן לייענען. איר קענט מעגליך אויך באקומען דעם דאָזיקן דאָקומענט אין אייער שפראך. פאר אומזיסטע הילף, ביטע קלינגט: 1-800-521-2651 (TTY: 711). (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'í' yídooltahígíí nihee hóló. Díí naaltsos t'áá Diné bizaad k'ehjí ályaago áldó' nich'í' ádoolníłgo bííghah. T'áá jíík'e shíká i' doolwoł nínizingo koji' béesh holdíílnih 1-800-521-2651 (TTY: 711). (Navajo)

## Non-Discrimination Disclosure

### Discrimination is Against the Law

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Delta Dental does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Delta Dental will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Delta Dental will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

Delta Dental  
P.O. Box 997330  
Sacramento, CA 95899-7330  
Telephone Number 866-530-9675  
Website Address: [deltadentalins.com](http://deltadentalins.com)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Delta Dental provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental also provides free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact Delta Dental customer service 866-530-9675.





Delta Dental Insurance Company

## CITY OF TALLAHASSEE



[deltadentalins.com](http://deltadentalins.com)

**Group No: 17452**

**Effective Date: January 1, 2015**

**This Certificate Contains a Deductible Provision.**

**DELTA DENTAL INSURANCE COMPANY**

1130 Sanctuary Parkway  
Suite 600  
Alpharetta, Georgia 30009  
(770) 641-5100  
(800) 521-2651

**DENTAL CERTIFICATE OF COVERAGE**

**Delta Dental PPO<sup>SM</sup> Program**

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental Insurance Company ("Delta Dental") and cannot modify the Contract in any way.



**Anthony S. Barth  
President**

## TABLE OF CONTENTS

|  |    |
|--|----|
| GROUP HIGHLIGHTS .....                   | 3  |
| DEFINITIONS .....                        | 4  |
| CHOICE OF DENTIST .....                  | 5  |
| WHO IS ELIGIBLE? .....                   | 6  |
| DEDUCTIBLE .....                         | 7  |
| MAXIMUM AMOUNT .....                     | 7  |
| BENEFITS, LIMITATIONS & EXCLUSIONS ..... | 8  |
| EXTENSION OF BENEFITS .....              | 13 |
| COORDINATION OF BENEFITS .....           | 13 |
| AUTOMATED INFORMATION LINE .....         | 14 |
| CLAIMS .....                             | 14 |
| PRE-TREATMENT ESTIMATE .....             | 14 |
| CLAIMS APPEAL .....                      | 14 |
| CANCELLATION OF CONTRACT .....           | 15 |
| GENERAL PROVISIONS .....                 | 15 |

## GROUP HIGHLIGHTS

**PLAN:**

You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1<sup>st</sup> through December 31<sup>st</sup>.

| <b>BENEFITS:</b>   | <i><b>PPO/PREMIER</b></i>               |  | <i><b>PPO PLUS</b></i>     |  |
|--|---|--|----------------------------|--|
|  | In-Network<br>PPO & Premier<br>Dentists | Out-of-Network<br>Non-Delta<br>Dental Dentists | In-Network<br>PPO Dentists | Out-of-Network<br>Premier and<br>Non-Delta<br>Dental Dentist |
| Diagnostic & Preventive Benefits:  | 100%                                    | 100%   | 100%                       | 80%  |
| Basic Benefits:  | 80%                                     | 80%  | 80%                        | 60%  |
| Major Benefits:  | 60%                                     | 50%  | 60%                        | 50%  |
| Orthodontic Benefits:  | 50%                                     | 50%  | 50%                        | 50%  |
| <b>DEDUCTIBLES:</b>  |   |  |                            |  |
| Per Enrollee per Calendar Year:  | \$25                                    | \$50   | \$25                       | \$50   |
| Per Family per Calendar Year:  | \$75                                    | \$150  | \$75                       | \$150  |
| Diagnostic and Preventive Benefits and Orthodontic Benefits are not subject to the deductible.   |   |  |                            |  |
| The Enrollee pays separate deductibles for In-Network Benefits and Out-of-Network Benefits each Calendar Year. If the Enrollee switches between the In-Network and Out-of-Network Benefits during a Calendar Year the Deductibles may be adjusted accordingly. The maximum deductible amounts in any Calendar Year will not exceed the Calendar Year Deductible for Out-of-Network Benefits.                     |   |  |                            |  |
| <b>MAXIMUMS AMOUNTS:</b>   |   |  |                            |  |
| Per Enrollee per Calendar Year:  | \$1,500                                 |  | \$1,500                    |  |
| Any expenses towards Diagnostic & Preventive Benefits will not be subject to the Calendar Year Maximum Amount.   |   |  |                            |  |
| Lifetime for Orthodontic Services per Dependent Child Enrollee:  | \$1,500                                 |  | \$1,800                    | \$1,500  |
| There are separate Orthodontic lifetime maximums under the <i><b>PPO Plus plan</b></i> . The lifetime maximum amount payable for In-Network and Out-of-Network Benefits will not exceed the lifetime maximum amount for In-Network Benefits (\$1,800). However, if only Out-of-Network Benefits are met, the Enrollee may still utilized an In-Network Dentist for the balance of the lifetime maximum of \$300. |   |  |                            |  |

**Lifetime Takeover Credit:** Delta Dental will receive credit for any amounts paid under the Contractholder’s previous dental care contract, if applicable, for Orthodontic Benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

**PREMIUMS:**

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

Delta Dental may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

**NOTICE:**

Since this information is being provided in electronic format, its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.

## DEFINITIONS

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

**Approved Amount** -- the maximum amount a Dentist may charge for a Single Procedure.

**Benefits (In-Network or Out-of-Network)** -- the amounts that Delta Dental will pay for dental services under this Contract.  
*PPO/Premier Plan*  
In-Network Benefits are those covered by this Contract and performed by a Delta Dental PPO Dentist or Delta Dental Premier® Dentist. Out-of-Network Benefits are those covered by this Contract but performed by a Non-Delta Dental Dentist.

*PPO Plus Plan*

In-Network Benefits are those covered by this Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by this Contract but performed by a Delta Dental Premier® Dentist or by a Non-Delta Dental Dentist.

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

**Contract** -- the written agreement under which Benefits are provided.

**Contract Allowance** -- the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement;
- by Delta Dental Premier Dentists (who are not Delta Dental PPO Dentists) is the lesser of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

**Contractholder** -- the employer, union or other organization or group contracting to obtain Benefits.

**Delta Dental PPO Dentist (PPO Dentist)** -- a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO fees as payment in full and comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

**Delta Dental PPO Dentist's Fee (PPO Dentist's Fee)** -- the fee for each Single Procedure that PPO Dentists have contractually agreed to accept as payment in full for treating PPO Enrollees.

**Delta Dental Premier Dentist (Premier Dentist)** -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

**Dentist** -- a person licensed to practice dentistry when and where services are performed.

**Dependent Enrollee** -- a dependent of a Primary Enrollee or domestic partner who is eligible for Benefits under the Contract.

**Effective Date** -- the date the program starts. This date is given on the booklet cover.

**Enrollee** -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

**Maximum Plan Allowance (MPA)** -- the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of network Dentist.

**Non-Delta Dental Dentist** -- a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

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

**Participating Dentist Agreement** -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

**Participating PPO Dentist Agreement (PPO Dentist Agreement)** -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a Delta Dental PPO program.

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

**Primary Enrollee** -- any employee or retiree eligible for Benefits under the Contract.

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

**Qualifying Status Change** -- a change in:

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

**Single Procedure** -- a dental procedure that is assigned a separate CDT number.

## CHOICE OF DENTIST

Enrollees may choose a Dentist from Delta Dental's panel of PPO Dentists and Premier Dentists, or Enrollees may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at [deltadentalins.com](http://deltadentalins.com). Enrollees are responsible for verifying whether the selected Dentist is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Enrollees should always confirm with the Dentist's office that a listed Dentist is still a participating PPO Dentist or Premier Dentist.

### *PPO Dentist*

The PPO program potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Dentists will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

### *Premier Dentist*

The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

### *Non-Delta Dental Dentist*

If a Dentist is a Non-Delta Dental Dentist, the amount charged to Enrollees may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the Dentist's submitted charge.

#### *Additional advantages of using a PPO Dentist or Premier Dentist*

- The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist will complete the dental Claim Form and submit it to Delta Dental for reimbursement.

### **WHO IS ELIGIBLE?**

#### **Eligibility for Enrollment**

You will become eligible to receive Benefits on the date stated in the Contract after completing any eligibility periods required by the Contractholder as stated in the Contract.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Lawful spouse or domestic partner named in Contractholder's guidelines for Domestic Partnership;
- Children from birth to the end of the Calendar Year of their 26<sup>th</sup> birthday. Children include natural children, step-children, adopted children, children of your domestic partner, foster children, custodial children and newborn children including a newborn child of a covered dependent child. Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children, foster children and custodial children are eligible from the moment of placement in the Enrollee's residence. Notice of birth, adoption placement, foster home placement or other custodial placement of a child with Enrollee must be received within 31 days of the birth or placement. If notice of birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.
- A child 26 years or older may continue to be eligible as a dependent if the child is not self-supporting because of physical handicap or mental incapacity that began before age 26 and the child is mostly dependent on the Eligible Employee for support and maintenance. Proof of incapacity will not be required until a claim has been denied due to a child having reached age 26. Proof of these facts must be given to Delta Dental or to the Contractholder within 31 days if it is requested. Proof will not be required more than once a year after the child is 28.

Dependents in military service are not eligible.

#### **Enrollment Requirements**

If you are paying all or a portion of premiums for yourself or your dependents then:

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period. If notice of a birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of a birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay Premiums in the manner elected by the Contractholder and approved by Delta Dental. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay Premiums for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental until your dependents are no longer eligible or until you choose to drop dependent coverage, coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

#### **Loss of Eligibility**

Your coverage ends on the last day of the month you stop working for the Contractholder or immediately when the Contract ends. Your dependents' coverage ends when your coverage ends or on the date when dependent status is lost.

### *Termination of Benefits on Voluntary Loss of Eligibility*

Delta Dental will not pay for Benefits for any services received after your coverage ends. However, Delta Dental will pay for a Single Procedure incurred when you were covered if such procedure is completed within 90 days of the Enrollee's voluntary termination of coverage. A dental service is incurred as follows:

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

### **Strike, Lay-off and Leave of Absence**

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

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

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

Coverage will resume the first day of the month after you return to work, provided you submit to Delta Dental an enrollment card requesting that coverage be reactivated.

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

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

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

### **Continued Coverage Under USERRA**

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date you fail to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

### **Continuation of Coverage Under (COBRA)**

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

## **DEDUCTIBLE**

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible, but you do not have to pay a deductible for Diagnostic and Preventive Benefits or Orthodontic Benefits.

## **MAXIMUM AMOUNT**

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.



## BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental will pay the Benefits for the types of dental services as described below. Delta Dental will pay Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of Florida, the Dentist will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract.

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

### Enrollee Coinsurance

Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

### BENEFITS

Delta Dental will pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for covered services.

## PPO/PREMIER

### Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.
- Preventive: prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Major Benefit) for payment purposes), topical application of fluoride solutions.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

### Basic Benefits:

- Simple Extraction: extraction of erupted tooth or exposed root.
- Palliative: treatment to relieve pain.
- Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Other Services: space maintainers.

**Major Benefits:**

- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.
- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.

**Orthodontic Benefits:**

Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.

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

**LIMITATIONS****Limitations on Diagnostic and Preventive Benefits:**

- Routine oral examinations and cleanings (including periodontal cleanings) are provided no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Major Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided once in a Calendar Year for you and your spouse and twice in a Calendar Year for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to Enrollees under age 19.
- Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) do not include repair or replacement of a sealant on any tooth within two (2) years of its application.

**Limitations on Basic Benefits:**

- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 14.

**Limitations on Major Benefits:**

- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.
- Delta Dental will not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
- Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in

supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.

- Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

#### **Limitations on Orthodontic Benefits:**

- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on the Group Highlights page.
- Orthodontic Benefits will be provided in two (2) payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months or less, one (1) payment will be made.
- Benefits are not paid to repair or replace any orthodontic appliance received under this program.
- Benefits are not provided for orthodontic retreatment procedures.
- Orthodontic Benefits are limited to Dependent Child Enrollees to the end of the Calendar Year of their 25<sup>th</sup> birthday.
- Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the Orthodontic coinsurance and lifetime maximum if covered as Benefits under Delta Dental's standard processing policies.

## PPO PLUS

#### **Diagnostic and Preventive Benefits:**

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.
- Preventive: prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Major Benefit) for payment purposes), topical application of fluoride solutions.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

#### **Basic Benefits:**

- Simple Extraction: extraction of erupted tooth or exposed root.
- Palliative: treatment to relieve pain.
- Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Other Services: space maintainers.

#### **Major Benefits:**

- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and re cementation.

- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.

### **Orthodontic Benefits:**

Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.

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

## **LIMITATIONS**

### **Limitations on Diagnostic and Preventive Benefits:**

- Routine oral examinations and cleanings (including periodontal cleanings) are provided no more than four (4) in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Major Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided once in a Calendar Year for you and your spouse and twice in a Calendar Year for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to Enrollees under age 19.
- Sealants are limited as follows:
  - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
  - (2) do not include repair or replacement of a sealant on any tooth within two (2) years of its application.

### **Limitations on Basic Benefits:**

- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.

### **Limitations on Major Benefits:**

- Space maintainers are limited to the initial appliance only and to Enrollees under age 14.
- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.
- Delta Dental will not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
- Prosthodontic appliances and/or implants that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

### **Limitations on Orthodontic Benefits:**

- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on the Group Highlights page.
- Orthodontic Benefits will be provided in two (2) payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500 or when the treatment plan is 12 months or less, one (1) payment will be made.
- Benefits are not paid to repair or replace any orthodontic appliance received under this program.

- Benefits are not provided for orthodontic retreatment procedures.
- Orthodontic Benefits are limited to Dependent Child Enrollees to the end of the Calendar Year of their 25<sup>th</sup> birthday.
- Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the Orthodontic coinsurance and lifetime maximum if covered as Benefits under Delta Dental's standard processing policies.

## BOTH PLANS

**Limitations on All Benefits - Optional Services** that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration; or
- a composite restoration instead of an amalgam restoration on posterior teeth.

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

### EXCLUSIONS

**Delta Dental does not pay Benefits for:**

- treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or dentistry for purely cosmetic reasons.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate (unless services for cleft palate are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn dependent children for medically diagnosed congenital defects, birth abnormalities or prematurity.
- treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.
- any Single Procedure started prior to the date the Enrollee became covered for such services under this program.
- prescribed drugs, medication, pain killers or experimental procedures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
- services or supplies covered by any other health plan of the Contractholder.

- treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section, if applicable.
- services for any disturbances of the temporomandibular (jaw) joints.

### **EXTENSION OF BENEFITS**

If the Contract terminates, an extension of benefits in the form of reimbursed expenses will apply if:

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

The extension of benefits terminates upon the earlier of:

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

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

All contractual limitations, exclusions or reductions that would have applied to the specific dental services had your coverage not terminated apply during the extension of benefits.

### **COORDINATION OF BENEFITS**

Delta Dental matches the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta Dental plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Dentist's fees for the covered services. If this is the "primary" program, Delta Dental will not reduce Benefits, but if the other program is the primary one, Delta Dental will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- *How does Delta Dental determine which Plan is the "primary" program?*
  - (1) If the other Plan is not primarily a dental plan, this Plan is primary.
  - (2) If the other Plan is a dental program, the following rules are applied:
    - a) the Plan covering the Enrollee as an employee is primary over a Plan covering the Enrollee as a dependent.
    - b) the Plan covering the Enrollee as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      - i) secondary to the Plan covering the insured person as a dependent and
      - ii) primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
  - (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
    - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
    - c) However, if the other Plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- d) In the case of a dependent child of legally separated or divorced parents, the Plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the Plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

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

- (4) The benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (5) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following will be the order of benefit determination:
- a) First, the benefits of a Plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
  - b) Second, the benefits under the continuation coverage.
- If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (6) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

#### **AUTOMATED INFORMATION LINE**

You may access Delta Dental's automated information line on a regular business day to obtain Enrollee eligibility and Benefits, group Benefit or claim status information or to speak to a Customer Service Representative for assistance. **(800) 521-2651**

#### **CLAIMS**

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

**Delta Dental Insurance Company**  
**P.O. Box #1809**  
**Alpharetta, Georgia 30023**  
**(800) 521-2651**  
**deltadentalins.com**

#### **PRE-TREATMENT ESTIMATE**

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the Enrollee's coverage ends; or
- the date the PPO Dentist's or Premier Dentist's agreement with Delta Dental ends.

#### **CLAIMS APPEAL**

Delta Dental will notify the Primary Enrollee if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reasons why the denial was wrong. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 15 days after Delta Dental receives the request for appeal. Delta Dental may ask for more documents if needed. In no event will the decision take longer than 15 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or

considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Enrollee believes he/she needs further review of said claim, he/she may contact his/her state insurance regulatory agency if applicable or bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the Contract is subject to ERISA.

## **CANCELLATION OF CONTRACT**

Delta Dental may cancel the Contract only:

- on an anniversary of the Effective Date upon 60 days written notice; or
- if your employer does not pay the monthly premiums upon 31 days written notice; or
- if your employer does not provide a list of who is eligible upon 60 days written notice; or
- if less than the minimum number of Primary Enrollees required under the Contract are reported eligible for three (3) months or more, upon 15 days written notice.

## **GENERAL PROVISIONS**

### **Clinical Examination**

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

### **Notice of Claim Forms**

Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the Enrollee is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### **Written Notice of Claim/Proof of Loss**

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

All written proof of loss must be given to Delta Dental within 12 months of the termination of the Contract.

### **Time of Payment**

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

- a) within 45 days after receipt of due written proof of such loss. If additional information is requested to process the claim, Delta will notify the Primary Enrollee and the Dentist within 45 days of written proof of loss; and
- b) within 60 days after the requested information is received for any disputed portion of the claim.

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



**To Whom Benefits are Paid**

PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting him.

**Legal Actions**

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

**THIS CERTIFICATE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL INSURANCE CONTRACT. THE COMPLETE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.**